REQUEST FOR EXAMINATION SPECIAL ACCOMMODATIONS

If you have a disability covered by a national Disabilities Program (e.g. Americans with Disabilities Act), and you wish to request an accommodation for a qualified disability, please complete this form and the Documentation of Disability-related Needs sheet so your request can be processed efficiently. The information you provide and any documentation regarding your disability and your need for accommodation in testing will be treated with strict confidentiality.

Applicant Information:

Last Name__________________ First Name_____________________ Middle Initial___________

Address ____

Address ____

City_______________________________ State__________ Zip Code ________________________

Special Accommodations:

I _________________________________ (your name) request special accommodations (please indicate in the table below), for the

Certified Construction Manager Examination (CCM)

Certified Associate Construction Manager Examination (CACM)

I understand that CMCI may require a fee to defray the costs of these accommodations, as may be permitted by law.

Please provide (check all that apply):

- ☐ Accessible testing site
- ☐ Special seating
- ☐ Reader
- ☐ Extended testing time
- ☐ Separate testing area
- ☐ Other ADA special accommodations as authorized by a qualified medical professional. (please specify) ____

Applicant's signature____ Date___________________

Health Care Provider Signature________________________________ Date ___________________

Return this form with your examination application information to the CMCI Office a minimum of 45 days prior to the date you wish to take the examination. This request will not be processed if it is not accompanied by a properly completed "Documentation of Disability-Related Needs" form.

Construction Manager Certification Institute
200 Lawyers Road NW, #1968, Vienna, VA 22183
703.356.2622 (o) | 703.356.6388 (f)
www.cmaanet.org| certification@cmaanet.org

Health Care Documentation of Disability-Related Needs

This section must be completed by a licensed health care provider who has been personally involved in the diagnosis or treatment of the disability for which you are requesting accommodation, OR an educational or testing professional who has previously provided you with testing accommodations similar to those requested.

Professional Documentation

I have known____ since ____________________.
Test Applicant Date

In my capacity as a ____
Professional Title

The applicant has discussed with me the nature of the test to be administered. It is my opinion that because of this applicant's disability described below, he/she should be accommodated by providing the special arrangements listed on the reverse side.
Comments: ____

____

____

____

Signed: ____

Print: ____

Title: ____Date:___________________

License # (if applicable) ___________________

Return this form with your examination application information and the Request For CCM Special Examination Accommodations to the CMCI Office a minimum of 45 days prior to the date you wish to take the examination. Please call the CMCI Office, if you have any questions about procedures in completing this application.

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