REQUEST FOR CMCI 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)
- ☐ Construction Manager-in-Training Examination (CMIT Level 1-4)

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 (time and a half)
- ☐ 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 _____

Construction Manager Certification Institute
703.356.2622 (o) | 703.356.6388 (f)
www.cmcertification.org | certification@cmaanet.org

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.

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. I believe 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 CMCI 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 the procedures for completing this application.

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