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) _____

Submit this form on the "Request for Exam ADA Special Accommodations" form 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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703.356.2622 (o) | 703.356.6388 (f)
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