

# REQUEST FOR ACCOMMODATION

## COURT INTERPRETER CREDENTIALING PROGRAM

This section must be completed by an appropriate professional (doctor, psychologist, psychiatrist, or education professional) to certify that your disabling condition requires the requested examination accommodation.

If you have existing documentation of having the same or similar accommodation provided to you in another test situation, you may submit such documentation instead of having this portion of the form completed.

I HAVE KNOWN \_\_\_\_\_ SINCE \_\_\_\_\_  
(APPLICANT NAME) (DATE)

AS A \_\_\_\_\_. I HAVE DIAGNOSED OR EVALUATED THE  
(PATIENT OR IN OTHER PROFESSIONAL RELATIONSHIP)

APPLICANT MYSELF, AND I AM NOT RELYING UPON FACTS RELATED TO ME BY THE APPLICANT.

MY DIAGNOSIS IS \_\_\_\_\_  
(DESCRIBE THE MEDICAL CONDITION OR OTHER CONDITION)

THE APPLICANT HAS DISCUSSED WITH ME THE NATURE OF THE TEST TO BE ADMINISTERED. IT IS MY PROFESSIONAL OPINION THAT BECAUSE OF THIS APPLICANT'S DISABILITY, THE APPLICANT SHOULD BE ACCOMMODATED BY PROVIDING THE FOLLOWING:

(CHECK ONLY THOSE THAT APPLY)

<input type="checkbox"/>	LARGE PRINT TYPE	<input type="checkbox"/>	EXTRA TIME (HOW MUCH?) _____
<input type="checkbox"/>	SEPARATE TESTING AREA	<input type="checkbox"/>	EXAMINATION READER
<input type="checkbox"/>	OTHER ORAL ADMINISTRATION (Please describe.)	<input type="checkbox"/>	OTHER ACCOMMODATIONS (Please describe.)

\_\_\_\_\_  
Signature of professional

\_\_\_\_\_  
Title of professional

\_\_\_\_\_  
Printed name of professional

\_\_\_\_\_  
Printed title of professional

Date: \_\_\_\_\_

Telephone: \_\_\_\_\_