# Request for BRPT Special Examination Accommodations

If you have a disability covered by a national Disabilities Program (e.g. Americans with Disabilities Act), and you wish to request accommodation for a qualified disability, please **complete this form and the Documentation of Disability-Related Needs** 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 Name/Initial ______________________________

Address (line 1) ______________________________

Address (line 2) ______________________________

City______________________ State__________ Zip Code ____________

## SPECIAL ACCOMMODATIONS

I request special accommodations (please indicate in the table below):

**Please provide (check all that apply):**

❏ Reader

❏ Extended testing time (time and a half)

❏ Separate testing area

❏ Other ADA special accommodations (please specify) ______________________________

______________________________

______________________________

______________________________

**Return this form with your examination application to the BRPT Executive Office. This request will not be processed if it is not accompanied by a properly completed "Documentation of Disability-Related Needs" form.** **(see next page)**

Applicant's signature______________________________ Date____________

# 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. **In addition to the below form, they must also include the following:**

- Formal letter on letterhead that has been signed and dated within the last month summarizing how your diagnosis/treatment is considered a disability under the ADA Act

- Recent (within the past 3 months) medical documentation of your diagnosis/treatment

## PROFESSIONAL DOCUMENTATION

I have known ______ *Test Applicant* ______ since (years) ______ *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 requested.

Comments: ______________________________

______________________________

______________________________

Signed: ______________________________

Title: ______________________________

Date: ______________________________ License # ______________________________
*# (if applicable)*

Return this form with your examination application to the BRPT Executive Office. Please call the BRPT office at **(202) 868-6747,** if you have any questions about the application or required documentation.

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