CPSI PAPER/PENCIL EXAM ADMINISTRATION

REQUEST FOR SPECIAL EXAMINATION ACCOMMODATIONS

If you have a disability covered by the Americans with Disabilities Act, please complete this form and the Documentation of Disability-Related Needs on the reverse side so your accommodations for testing 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. Please return this form to NRPA within 45 days of the desired testing date.

CANDIDATE INFORMATION

___________________________________________________________________________________________ ______________
Name (Last, First, Middle Initial, Former Name)

___________________________________________________________________________________________________________________________________
Mailing Address

___________________________________________________________________________________________________________________________________
City         State      Zip Code

___________________________________________________________________________________________________________________________________
Daytime Telephone Number

SPECIAL ACCOMMODATIONS

I request special accommodations for the CPSI exam on ___________________ in _________________________.

(date)        (city, state)

Please provide (check all that apply):

_____ Extended examination time (time and a half)

_____ Please specify below if other special accommodations are needed.

_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Comments: ___________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Signed:__________________________________   Date: ___________________________
DOCUMENTATION OF
DISABILITY-RELATED NEEDS

Please have this section completed by an appropriate professional (education professional, physician, psychologist, psychiatrist) to ensure that NRPA is able to provide the required examination accommodations.

PROFESSIONAL DOCUMENTATION

I have known __________________________ since _____ / _____ / _____ in my capacity as a
Examination Candidate           Date
___________________________________________.
Professional Title

The candidate discussed with me the nature of the examination to be administered. It is my opinion that, because of this candidate’s disability described below, he/she should be accommodated by providing the special arrangements listed on the reverse side.

Description of Disability:
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

Signed: ________________________________________ Title: ______________________________
Printed Name: ______________________________________________________________________________
Address: ___________________________________________________________________________________
__________________________________________________________________________________________
Telephone Number: __________________________________________________________________________
Date: ______________________ License # (if applicable): ____________________________________________

Please submit completed requests, along with any supporting documentation, to certification@nrpa.org