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 _________________________.

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: __________________________

Return this form to Terrence Johnson at tjohnson@nrpa.org or NRPA, 22377 Belmont Ridge Road, Ashburn, VA 20148 or
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): __________________________

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