



International Foundation for Retirement Education

SPECIAL TESTING ACCOMMODATION REQUEST FORM

In order to have your request considered for special testing accommodations for a disability covered by the Americans with Disabilities Act, complete this form and have an appropriate licensed professional complete the Documentation of Disability-Related Needs Form.

Applicant Information

Name _____

Address _____

Address _____

City _____ State _____ Zip Code _____

Special Testing Accommodations

Exam Date and Location (test center) for which you are requesting accommodation:

I would like to request the following testing accommodation(s):

- An oral examination by an authorized proctor
- Extended testing time (time and a half)
- A magnified Screen
- A paper and pencil examination
- An elevated monitor
- Other special accommodations (please specify):



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DOCUMENTATION OF DISABILITY-RELATED NEEDS BY QUALIFIED PROVIDER

This form must be completed by a licensed health care provider or an educational / testing professional. The nature of the disability, identification of the test(s) used to confirm the diagnosis, a description of past accommodations made for the disability, and the specific testing accommodations requested must be included.

Professional Documentation

I have known _____ since _____ in my capacity as a(n)
(Name of Applicant) (Date)

(Professional Title)

The applicant discussed with me the nature of the test being 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 Special Testing Accommodation Request Form.

Comments on Disability:

Signature: _____

Title: _____

Organization: _____

License # (if applicable): _____

Phone Number: _____ Date: _____

Candidate Instructions: Return this form with a copy of the Special Testing Accommodation Request Form to:

InFRE
P.O. Box 524
Barrington, IL 60011-0524
Or fax this form to: 847-756-7350