

## MATH PLACEMENT EXAMINATION REQUEST FOR TESTING ACCOMMODATIONS

This form must be completed by the student who is requesting the accommodations.

### APPLICANT INFORMATION

Your Name: \_\_\_\_\_

Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

Requested Test Date:      /      /      Requested Test Location: \_\_\_\_\_  
Mo Day Yr

Day phone # (Voice/TTY): \_\_\_\_\_ Evening phone # (Voice/TTY): \_\_\_\_\_

Fax #: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Nature of your disability (Check all that apply.)

- |  |  |
|--|--|
| <input type="checkbox"/> 1 ADD/ADHD            | <input type="checkbox"/> 5 Deaf  |
| <input type="checkbox"/> 2 Learning disability | <input type="checkbox"/> 6 Hard of hearing                               |
| <input type="checkbox"/> 3 Blind               | <input type="checkbox"/> 7 Psychological disability                      |
| <input type="checkbox"/> 4 Visually impaired   | <input type="checkbox"/> 8 Physical disability (Please describe.): _____ |
|  | <input type="checkbox"/> 9 Other (Please describe.): _____               |

Date of physician/professional's most recent evaluation: Month \_\_\_\_\_ Year \_\_\_\_\_

### VERIFICATION STATEMENT

I attest that the information recorded on this form is true.

\_\_\_\_\_  
Signature (do not print)

\_\_\_\_\_  
Date

### ACCOMMODATIONS REQUESTED

**Requested accommodations must be supported by documentation from a professional who is licensed and certified to diagnose your disability.**

(Check all that apply.)

#### Extended Testing Time

- 50% (time and one-half)  
 100% (double time)

#### Other Accommodations

- Please describe:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## CERTIFICATION OF ELIGIBILITY

Student Name: \_\_\_\_\_  
Last (please print) First M.I.

This form **MUST** be completed and signed by a certified professional, medical specialist or appropriate professional in an educational institution who has this documentation on file. Complete this section *only if* the documentation you have on file for the student meets the criteria below.

### Documentation Criteria

Documentation to support the need for requested accommodation(s) **must**

- state the diagnosed disability;
- be current, within the last 3 years, or 5 years for LD (does not apply to physical or sensory disabilities of a permanent or unchanging nature);
- include educational, developmental, and medical history relevant to the disability for which testing accommodations are being requested;
- describe the functional limitations resulting from the disability and list the tests or techniques used to arrive at the diagnosis of the disability (include evaluation date[s] and test results with relevant subtest scores);
- must justify the specific accommodations requested;
  
- appear on official letterhead by an evaluator qualified to make the diagnosis (include information about license or certification and area of specialization).

### VERIFICATION STATEMENT TO BE SIGNED BY CERTIFYING PROFESSIONAL

I certify that the accommodations requested are those that were documented as necessary for the student.

\_\_\_\_\_  
Signature of Certifying Professional

\_\_\_\_\_  
Professional Title

\_\_\_\_\_  
Name (print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Institution/Agency

\_\_\_\_\_  
Telephone/TTY #

\_\_\_\_\_  
Fax #

\_\_\_\_\_  
E-Mail Address

### VERIFICATION STATEMENT TO BE SIGNED BY THE STUDENT

I certify that the information provided above about me is true to the best of my knowledge. I understand that this information must be available sufficiently in advance of the test date to provide time to evaluate and process my request for accommodations. I have not altered or revised the certification in any way after it was completed. I understand this information will be considered confidential.

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date