SPECIAL ACCOMOCATIONS FORM

To be completed by the Examinee (or Examinee's Advocate) (This section must be completed)

Name: _____

Date of Birth: _____ Age: _____

Address_____

_____

City_____State:_____Zip:_____

Briefly describe the level of the disability

_____

_____

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Briefly describe the effect of the disability as it relates to the examinee's performance on a paperbased Academic assessment

_____

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_____

"Other" Accommodations Not Listed

If other accommodations are needed, please provide detailed instructions about the accommodation, how the accommodation should be implemented, and any materials or equipment that might be needed in conjunction with the accommodation.

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I have submitted education, medical, and/or psychological records needed to justify approval of the testing accommodations for which I have applied. I understand that the document(s) will be reviewed by testing accommodations administrators. The records will be kept confidential. However, if an inquiry is made into the status of my application, I grant permission for ACBN to provide such status to individuals named in this or state department accommodations administrators, or the test center.

Examinee's Signature: _____

ACBN Signature_____