



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 and submit it with your application at least 45 days prior to your requested examination date.** The information you provide and any documentation regarding your disability and your need for accommodation in testing will be treated with strict confidentiality.

Candidate Information

Requested Location _____

Social Security # or ID # _____

Requested Examination Date: _____

Name (Last, First, Middle Initial, Former Name) _____

Mailing Address _____

City _____ State _____ Zip Code _____

Daytime Telephone Number _____

Special Accommodations

I request special accommodations for the following examination: CSCS CPT

Examination delivery method: Computer-based Testing Paper-and-pencil Testing

Please provide (check all that apply):

- Reader
- Extended testing time (time and a half)
- Reduced distraction environment
- Please specify below if other special accommodations are needed.

Comments: _____

PLEASE READ AND SIGN:

I give my permission for my diagnosing professional to discuss with AMP staff my records and history as they relate to the requested accommodation.

Signature: _____ Date: _____

Return this form to:

Examination Services, AMP, 18000 W. 105th Street, Olathe, KS 66061-7543, Fax 913/895-4650.

If you have questions, call the Candidate Support Center at 888/519-9901.



DOCUMENTATION OF DISABILITY-RELATED NEEDS

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

Professional Documentation

I have known _____ since ____ / ____ / ____ in my capacity as a

Candidate Name

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: _____ Email Address: _____

Date: _____ License # (if applicable): _____

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