



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.

Candidate Information (ETCP/AMP Identification Number)

Social Security # _____ - _____ - _____ Requested Assessment Center: _____

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

Mailing Address

City State Zip Code

Daytime Telephone Number

Special Accommodations

I request special accommodations for the _____ examination.

Please provide (check all that apply):

- Special seating or other physical accommodations
- Reader
- Extended testing time (time and a half)
- Distraction-free room
- Other special accommodations (Please specify.)

Comments: _____

Signed: _____ Date: _____

**Return this form with your examination application and fee to:
ETCP, 630 Ninth Ave, Suite 609, New York, NY 10036.
If you have questions, call AMP at 913/895-4600
or ETCP at 212/244-1505, ext. 705**

