

(ETCP/AMP Identification Number)



DOCUMENTATION OF DISABILITY-RELATED NEEDS

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

Professional Documentation

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

Description of Disability: _____

Signed: _____ Title: _____

Printed Name: _____

Address: _____

Telephone Number: _____ E-mail Address: _____

Date: _____ License # (if applicable): _____

**Return this form with your examination application and fee to:
ETCP, 630 Ninth Avenue, Suite 609, New York, NY 10036
If you have questions, call PSI at 913/895-4600
or ETCP at 212/244-2505, ext. 705.**