



8. How long ago was your disability first professionally diagnosed?

< 1 year

1-2 years

3-4 years

> 4 years

9. What accommodation(s) are you requesting? *Accommodation(s) must be appropriate to the disability.*

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10. If you are requesting additional time, please indicate the amount of time supported by your documentation.

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Double time

Other (specify)

11. Do you require wheelchair access to the examination facility? Yes No

12. Prior test accommodations that you have received on

**STANDARDIZED EXAMINATIONS:**

a. Scholastic Aptitude Test (SAT): Month/Year \_\_\_\_\_ / \_\_\_\_\_

Accommodations received \_\_\_\_\_

b. American College Testing Program (ACT): Month/Year \_\_\_\_\_ / \_\_\_\_\_

Accommodations received \_\_\_\_\_

c. Graduate Record Examination (GRE): Month/Year \_\_\_\_\_ / \_\_\_\_\_

Accommodations received \_\_\_\_\_

d. National Licensing Examination (EPPP): Month/Year \_\_\_\_\_ / \_\_\_\_\_

Accommodations received \_\_\_\_\_

e. State Licensing Examination:

State \_\_\_\_\_ Month/Year \_\_\_\_\_ / \_\_\_\_\_

Accommodations received \_\_\_\_\_

f. Graduate School:

Name of School \_\_\_\_\_ Month/Year \_\_\_\_\_ / \_\_\_\_\_

Accommodations received \_\_\_\_\_

g. American Board of Professional Psychology (ABPP):

Specialty Board \_\_\_\_\_

Month/Year \_\_\_\_\_ / \_\_\_\_\_

Accommodations received \_\_\_\_\_

h. Other Board Certification:

Specialty Board \_\_\_\_\_

Month/Year \_\_\_\_\_ / \_\_\_\_\_

Accommodations received \_\_\_\_\_

13. I certify that the above information is true and accurate. If test accommodations provided to me include a deviation from the standard testing schedule, I agree that, from the time I begin the examination until I have completed it, I will not communicate in any way, to the extent possible, with any other individuals taking the examination, and I will not communicate in any way to others about the content of the examination.

If clarification of further information regarding the documentation provided is needed, I authorize the ABCN to contact the professional(s) who diagnosed the disability and/or those entities which have provided me test accommodations. I authorize such professional(s) and entities to communicate with the ABCN in this regard and to provide the ABCN with such clarification and/or further information.

Signature \_\_\_\_\_ Date \_\_\_\_\_