DOCUMENTATION OF DISABILITY-RELATED NEEDS

Please have this section completed by an appropriate professional (physician, psychologist, psychiatrist) to ensure that the Prevention Specialist Certification Board of Washington (PSCBW) is able to provide the required exam accommodations.

Professional Documentation

I have known ____ since _____/_____/_____ in my
Exam Candidate Date

capacity as a ____.
Professional Title

The candidate discussed with me the nature of the exam to be administered. It is my professional 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: ____

____

____

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____

____

Signed: ____ Title: ____________________________

Printed Name: ____

Address: ____

City/State/Zip: ____

Telephone Number: ______________________________ Email: ______________________________

License Number: ________________________________ Date: ________________________________
(if applicable)

Complete both sides of this form and return to the Prevention Specialist Certification Board of Washington (PSCBW) Testing Chair at least 60 days prior to exam date:

Leanne Reid, Testing Chair
PSCBW
PO Box 7172
Spokane, WA 99207

REQUEST FOR SPECIAL EXAMINATION ACCOMMODATIONS

If you have a disability covered by the Americans with Disabilities, 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 accommodations in testing will be treated with strict confidentiality.

Candidate Information Social Security # ________- ________ - ________

Exam Date: ___________________________ Exam Location: ________________________________

Name: ____

Home Address: ____

City/State/Zip: ____

Daytime Telephone Number: ____

Email: ____

Special Accommodations

I request special accommodations for the ___________________________________ examination.

Please provide (check all that apply):

________ Special seating or other physical accommodations

________ Reader

________ Large print exam booklet

________ Extended testing time (time and a half)

________ Distraction-free room

________ Other special accommodations (please specify)

____

____

____

____

Comments: ____

____

Signed:____ Date: ______________________________

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Leanne Reid, Testing Chair
PSCBW
PO Box 7172
Spokane, WA 99207