



REQUEST FOR SPECIAL EXAMINATION ACCOMMODATIONS

If you have a disability covered by the Americans with Disabilities Act, **please complete this form and provide the Documentation of Disability-Related Needs on the next page and submit both pages 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

Candidate ID # _____ Requested Test Center: _____

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

Mailing Address

City State Zip Code

Daytime Telephone Number Email Address

Special Accommodations

I request special accommodations for the _____ examination.

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 PSI staff my records and history as they relate to the requested accommodation.

Signature: _____ Date: _____

**Return this form with your examination application and fee to:
Certifying Board for Dietary Managers
406 Surrey Woods Drive | St. Charles, IL 60174
If you have questions, call the PDS Department at 800.323.1908.**



DOCUMENTATION OF DISABILITY-RELATED NEEDS

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

Professional Documentation

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

My Professional Title

The candidate discussed with me the nature of the test 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 Request for Special Examination Accommodations form.

Description of Disability: _____

Signed: _____ Title: _____

Printed Name: _____

Address: _____

Telephone Number: _____ Email Address: _____

Date: _____ License # (if applicable): _____

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