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.

Rev. 10/5/2018
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

<table>
<thead>
<tr>
<th>Candidate Name</th>
<th>Date</th>
</tr>
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<tbody>
<tr>
<td>My Professional Title</td>
<td></td>
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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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