

NCIDQ Examination

TESTING ACCOMMODATIONS REQUEST FORM

CIDQ is fully committed to providing reasonable testing accommodations for all individuals with disabilities covered by the Americans with Disabilities Act (ADA) (or the Canadian equivalent). Requests for testing accommodations for a documented disability are considered on a case-by-case basis.

Candidates requesting Testing Accommodations **MUST** complete and submit this application form and wait for approval of accommodations **PRIOR TO** scheduling an exam appointment with Prometric.

This form should be uploaded to a candidate's MyNCIDQ account during the application process. Once the Testing Accommodations Request form has been reviewed, the results will be emailed to candidates and will also be viewable via a candidate's MyNCIDQ account. Requests for testing accommodations should be made **at least 30 days prior** to the opening of the exam administration period.

Candidate must have a qualified licensed professional complete the Professional Evaluation section of this form. The professional must be an individual qualified to assess, diagnose and treat the stated disability. Any information and documentation provided regarding the need for accommodations in testing will be kept strictly confidential and will be shared only to the extent necessary with our testing vendor.

I. Candidate Information:

NAME

EMAIL ADDRESS

ADDRESS

CITY

STATE/PROVINCE

POSTAL CODE

COUNTRY

CONTROL NUMBER

II. Testing Accommodations Request

Have you ever been granted testing accommodations?

- ☐ YES
☐ NO

If YES, please document at least one instance where testing accommodations for a similar testing experience was granted.

Year of Accommodation	Type of Accommodation	Name of Institute/Organization that Provided Accommodation

I certify that the information provided is true and accurate. I understand that CIDQ will disclose information, as necessary, to Prometric, our testing vendor, for the sole purpose of establishing the requested testing accommodation(s). Such information will be treated in strict confidence, in accordance with the CIDQ Privacy Policy.

PRINTED NAME

SIGNATURE

DATE

III. Professional Evaluation (to be completed by a qualified health care professional)

DOCUMENTATION OF DISABILITY-RELATED NEEDS BY QUALIFIED PROFESSIONAL*

A qualified health care professional (i.e. physician, psychologist, psychiatrist) must complete this section to ensure that CIDQ is able to provide the appropriate accommodations for taking the NCIDQ exam.

NAME OF PROFESSIONAL	TITLE	OCCUPATION
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PRIMARY MAILING ADDRESS

CITY	STATE/PROVINCE	ZIP/POSTAL CODE	COUNTRY
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PHONE	EMAIL
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***MUST be licensed/certified to assess, diagnose and treat the stated disability.**

I have known _____ since ____/____/____ in my capacity as a(n)
CANDIDATE'S NAME

PROFESSIONAL TITLE

Based on your professional assessment, please provide the following information: (1) the length of time you have treated the candidate and whether treatment has ended or is ongoing, (2) the specific diagnosed condition as it relates to the candidate's ability to sit for the NCIDQ exam, (3) a description of how the diagnosis will affect the candidate's ability to sit for the NCIDQ exam, (4) how long you expect the candidate's limitations to continue, such that they will continue to require the testing accommodation. (5) if frequent breaks are required, provide specifics as to how many and how long the breaks need to be.

DESCRIPTION OF DISABILITY

SPECIFIC ACCOMMODATION(S) REQUESTED

The candidate discussed with me the nature of the exam to be administered. It is my professional opinion that because of this applicant's disability, described above, he or she should be provided with the testing accommodations identified.

PROFESSIONAL'S SIGNATURE

DATE

PROFESSIONAL'S PRINTED NAME

PROFESSIONAL'S TITLE

LICENSE NUMBER