Dear Candidate,

To apply for Reasonable Accommodation related to the Americans with Disability Act (ADA) for your exam(s), you must fill out Form A and provide supporting documentation and submit them by mail to National Testing Network (NTN). If you do not have supporting documentation, please submit Form B, to be filled out by a physician.

NTN will consider all requests for Reasonable Testing Accommodation. Candidates will be informed of the decision in writing within 5-7 business days of receipt of completed paperwork.

Please follow these steps:

1. **Do not schedule your exam.** Your accommodations must be approved before you can schedule your exam.
2. Fill in these forms completely and mail them to National Testing Network at the address below or fax (425) 977-0566. Please include your supporting documentation.
3. NTN will inform you of their decision.
4. Once you have approval NTN will help you schedule your exam.

When you have completed the forms mail them to this address:

National Testing Network
Accommodation Request
2122 164th ST SW
Suite 300
Lynnwood, WA 98087

All sections of the forms must be completed; if one of the sections does not apply, please complete it as "*not applicable*". Additional information may be required if forms are not filled out completely.

Things to check before you submit your forms:

1. Any submitted documentation needs to clearly state the nature and extent of the limitations the candidate possesses due to the diagnosed disability.
2. Paperwork must be current and dated within the last 3 years.

Best regards,

National Testing Network
www.NationalTestingNetwork.com
www.NTNLicensingExams.com
www.CosmetologyKansas.com

FORM A

REASONABLE TESTING ACCOMMODATIONS QUESTIONNAIRE
(To be completed by all applicants who request reasonable testing accommodations)

NOTE: Applicants are responsible for completeness and accuracy of the information provided.

(Please Type or Print)
Background Information

Applicant Name: _____
Address: _____
City, State, Zip: _____
Telephone Number: _____
Email Address: _____

What exam are you requesting accommodations for: _____
Written: _____Physical/Practical: _____

Nature of disability (Check all that apply)

_____ Hearing impaired
_____ Other physical disability
_____ Psychological disability
_____ Other
_____ Specific learning disability
_____ Chronic health problem
_____ Temporary accidental injury

Please provide a statement describing the nature and extent of your disability and how it affects your day to day life.

_____
_____
_____

How long have you had your disability?

_____ 1 to 3 years _____ 5 years _____ Most of my life

Past Classroom or Testing Accommodations Received

	YES	NO
Were you in a specific school or program to accommodate your disability?	_____	_____
Did you receive accommodations for classroom tests?	_____	_____
Date Received: _____		
Did you receive additional testing time for classroom tests?	_____	_____

If yes, please indicate the amount of extra time given: _____
Please describe any additional accommodations you were granted while in school.

Requested Accommodations:	Written Test	Physical/Practical
Use of a reader	_____	_____
Rest Period	_____	_____
Additional testing time for each test session	_____	_____
Other accommodations requested (please specify below)		

The use of email and electronic correspondence with the National Testing Network, in regards to requested accommodations must be authorized. If you choose to not approve this correspondence option, National Testing Network will only contact you through phone and fax. I agree to not hold National Testing Network responsible for any liability for release of the confidential information due to the other form of communication.

I approve email correspondence _____ I do not approve email correspondence _____

_____

Applicant's Signature Date

I certify that all the information on this form is true and correct to the best of my knowledge and belief. I understand this information may be reviewed by a physician retained by the administration company to assist in determining reasonable accommodations.

_____

Applicant's Signature Date

Supporting Documentation:

National Testing Network requires supporting documentation from an accredited entity that clearly defines the candidate's disability and recommended accommodations.

The submitted documentation must clearly state the applicant's distinct and substantial functional limitations caused by the applicant's disability. The documentation must also state how the limitations hamper the testing.

National Testing Network requires current documentation (within the last three (3) years). This does not apply for chronic disabilities.

Please also provide any previous evaluation documentation of the disability for review.

Some examples of documentation that can be submitted:

Dr. Letter and/or Note
Applicant's Individual Education Plan

FORM B

REASONABLE TESTING ACCOMMODATIONS – DISABILITY DOCUMENTATION
(To be completed by a physician)

NOTE: National Testing Network requires current documentation (within the last three (3) years) from a physician in the field related to the applicant's disability.

Physician Name: _____Title:_____
License/Certification Number: _____
Address: _____
Telephone Number: _____
RE: Applicant Name: _____

Please describe your credentials that qualify you to diagnose and/or verify the applicant's disability and to recommend an accommodation: _____
_____

Briefly describe the nature of the condition and describe how this condition affects the applicant:
_____

Current treatment consisted of: _____
Last date of treatment-date of consultation with applicant: _____
Length of treatment with applicant: _____
Is this a permanent condition/disability? _____YES _____ NO
If no, when is the condition/disability likely to abate? _____
In what way does the condition/disability affect the applicant's ability to read, write and/or concentrate for extended periods of time? _____

Based on this person's disability and your diagnosis, what testing accommodations would you recommend? (Check all that would apply.)

Requested Accommodations:	Written Test	Practical/Physical Test
Use of a reader	_____	_____
Rest Period	_____	_____
Additional testing time for each test session	_____	_____
Other accommodations requested (please specify below)	_____	_____

_____
_____

I certify that all the information on this form is true and correct to the best of my knowledge and belief. I understand this information may be reviewed by a physician retained by the administration company to assist in determining reasonable testing accommodations.

_____
Physician's Signature Date

_____
Print Physician Name