

**Special Testing Accommodation Request Form  
And Documentation of Disability-Related Needs Form**

## **Special Testing Accommodation Request Form**

Candidates with disabilities covered by the Americans with Disabilities Act (or Canadian/Australian equivalent) must complete this form and have an appropriate licensed professional complete the Documentation of Disability-Related Needs Form in order for their accommodations request to be processed.

### **Applicant Information**

Name: \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

### **Special Testing Accommodations**

Exam Date and Location (test center) for which you are requesting accommodation:

\_\_\_\_\_

I would like to request the following testing accommodation(s):

- Use a written test booklet and fill-in answer sheet
- Extended testing time (time and a half)
- Large print test. Point size: \_\_\_\_\_ (up to 16 point)
- Reader
- Separate testing area
- Special seating, please describe: \_\_\_\_\_
- Wheelchair accessible testing site
- Other special accommodations (please specify):

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**DOCUMENTATION OF DISABILITY-RELATED NEEDS  
BY QUALIFIED PROVIDER**

This form must be completed by a licensed or otherwise properly credentialed health care provider with expertise in the disability for which modifications or accommodations are sought. The nature of the disability, identification of the test(s) used to confirm the diagnosis, a description of past accommodations made for the disability, and the specific testing accommodations requested must be included.

**Professional Documentation**

I have known \_\_\_\_\_ since \_\_\_\_\_ in my capacity as a(n)  
(Name of Applicant) (Date)

\_\_\_\_\_  
(Professional Title)

The applicant discussed with me the nature of the test being administered. It is my opinion that because of this applicant's disability described below, he/she should be accommodated by providing the special arrangements listed on the Special Testing Accommodation Request Form.

Comments on Disability:

Signature: \_\_\_\_\_

Title: \_\_\_\_\_

Organization: \_\_\_\_\_

License # (if applicable): \_\_\_\_\_

Phone Number: \_\_\_\_\_

Date: \_\_\_\_\_

Candidate Instructions: Return this form with a copy of the Special Testing Accommodation Request Form to CA-NV AWWA Certification Department.

Postal mail to Gina Enriquez, Certification Supervisor  
10435 Ashford Street  
Rancho Cucamonga, CA 91730  
Email attachments to [genriquez@ca-nv-awwa.org](mailto:genriquez@ca-nv-awwa.org)