Guidelines for Documenting a Request for Testing Accommodations

The following guidelines will assist applicants in documenting a need for testing accommodations based on a physical or mental impairment that substantially limits one or more major life activities (or major bodily functions) important to taking the examination. Major life activities are basic activities that most people in the general population are able to perform with little or no difficulty. These include, but are not limited to, activities like seeing, hearing, performing manual tasks, speaking, breathing, concentrating, reading, thinking, learning or working.

To request accommodations, please submit the following:

1. A completed NCCCO Application for Testing Accommodations, attaching all documentation/verifications as necessary or appropriate.

2. A report of a professional evaluation or appropriate records from a qualified professional who has examined or treated you for the disabling condition(s) to substantiate the claimed physical or mental impairment and the nature and degree of limitations in performing a major life activity (or bodily function).

Assessment reports or records must provide the following information:

- The report or provider records should state a specific diagnosis using professionally recognized criteria such as those from the ICD-10 or DSM-V (or most recent versions).
- The report or provider records should provide a detailed description of the observed signs, reported symptoms, and any objective test findings that support the diagnosed condition(s).
- Where objective tests and psychometric or quantified evaluation procedures have been used, these should be identified by name and the results reported in detail. When used, tests of cognitive and academic abilities must be reported (or appended) using norms based upon age of the applicant (as available) at the time the examination was conducted.
- In instances where a developmental disorder has been diagnosed, a childhood history of abnormalities consistent with the diagnosis must be documented and verified through objective and independent sources other than the applicant report. This includes cases of specific learning disorder and attention deficit hyperactivity disorder. (Applicants may independently provide records of childhood impairments.)
- The report or records must clearly reflect the nature and degree of limitations in performing a major life activity (or bodily function) and demonstrate the presence of disabling impairment in the types of activities required to access the certification examination. (Additional records or documents from other reliable sources may also be submitted to show disabled functioning.)

Provide the following regarding the evaluating or treating provider:
- Type of license, date issued, and expiration date
- License number
- State or jurisdiction in which license is issued
- Full name, address, business phone number and email address

*The professional report or records must be current and no more than three years old. Written assessment reports must be on the provider’s letterhead, dated, and signed.*