

**REQUEST FOR SPECIAL EXAMINATION ACCOMMODATIONS**

Please complete this form and the “Documentation of Disability-Related Needs” form on page 27 so the accommodation for testing can be processed efficiently. The information provided and any documentation regarding the candidate’s disability and need for accommodation in testing will be considered strictly confidential and will not be shared with any outside source without the candidate’s express written consent. Candidates who have existing documentation of the same or similar accommodation(s) provided for them in another examination situation may submit such documentation instead of completing the “Professional Documentation” portion of this form.

**Applicant Information**

Candidate ID number: \_\_\_\_\_  
Last Name: \_\_\_\_\_  
First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Daytime Phone Number: \_\_\_\_\_ Fax: \_\_\_\_\_  
Email: \_\_\_\_\_

**Special Accommodations:**

Please provide (check all that apply)

- \_\_\_\_\_ Special seating or other physical accommodations
- \_\_\_\_\_ Magnifying screen for examination
- \_\_\_\_\_ Reader
- \_\_\_\_\_ Extended testing time (normally 1.5 additional hours)
- \_\_\_\_\_ Separate testing area
- \_\_\_\_\_ Other special accommodations (please specify)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_

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

**Return this form to:**  
NLN Customer Service & Scoring Center  
Academic Nurse Educator Certification Program  
148 E. Pleasant Hill Rd. Suite 109  
Carbondale, IL 62903

**Also, please contact the NLN’s Academic Nurse Educator Certification Program at 618-453-5869 or certification@nln.org to inform us that you have submitted an online registration form and are mailing in the Request for Special Accommodations and Documentation of Disability-Related Needs forms.**

**DOCUMENTATION OF DISABILITY-RELATED NEEDS**

Candidates who have a learning disability, a psychological disability, or other disability that requires an accommodation in testing, please have this section completed by an appropriate professional (education professional, doctor, psychologist, psychiatrist) to certify that the candidate’s disabling condition requires the requested test accommodation. Candidates who have existing documentation of the same or similar accommodation provided for them in another examination situation, may submit such documentation instead of completing the “Professional Documentation” portion of this form.

**Professional Documentation**

I have known \_\_\_\_\_ since \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Candidate’s name Date

in my capacity as a(n) \_\_\_\_\_ .  
Professional Title

The applicant discussed with me the nature of the test to be 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 reverse side.

Description of Disability:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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

Address:  
\_\_\_\_\_  
\_\_\_\_\_

Telephone Number: \_\_\_\_\_

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

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