



ALPP Special Testing Accommodation Request Form

Advanced Lactation Consultant (ALC)

Name _____

Home Address _____

City _____ State _____ Zip _____

Daytime Phone _____

Email Address _____

Date of ALC Certification _____

Location of ALC Examination _____

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.

Special Testing Accommodations

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

- Circle answers in test booklet
- Extended testing time (time and a half)
- Large print test. Point size: _____
- Reader
- Separate testing area
- Special seating, please describe: _____
- Wheelchair accessible testing site
- Other special accommodations (please specify): _____

Send completed application to:

Academy of Lactation Policy and Practice

Dept. Certification/Recertification ALC

PO Box 1288

Forestdale, MA 02644

OR fax to: (508)-833-6070



Applicant Signature: _____

***** (Office use only) *****

Approved

Denied

Reason:

 Date

 Authorized ALPP Representative

PLEASE NOTE: All special testing accommodations must be requested at least 4 weeks prior to the examination date through the Academy of Lactation Policy & Practice.

Send completed application to:
 Academy of Lactation Policy and Practice
 Dept. Certification/Recertification ALC
 PO Box 1288
 Forestdale, MA 02644
 OR fax to: (508)-833-6070



ALPP Documentation of Disability-Related Needs by Qualified Provider

Advanced Lactation Consultant (ALC)

Name _____

Home Address _____

City _____ State _____ Zip _____

Daytime Phone _____

Email Address _____

Date of ALC Certification _____

Location of ALC Examination _____

This form must be completed by a licensed health care provider or an educational / testing professional. 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 _____ as a(n) _____.

(Name of Applicant) (Date)

 (Professional Title) (Board Certification)

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: _____

Send completed application to:
 Academy of Lactation Policy and Practice
 Dept. Certification/Recertification ALC
 PO Box 1288
 Forestdale, MA 02644
 OR fax to: (508)-833-6070



Signature: _____

Title: _____

Organization: _____

License # (if applicable): _____

Phone Number: _____ Date: _____

Candidate Instructions: Return this form with a copy of the *Special Testing Accommodation Request Form*

Written accommodation requests may also be scanned and submitted via email to:
info@alpp.org with the words: *Accommodation Request* in the subject line of the email.

Send completed application to:
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