



ALPP Special Testing Accommodation Request Form for the Online Certified Lactation Counselor (CLC) Certification Exam

Name _____

Home Address _____

City _____ State _____ Zip _____

Daytime Phone _____

Email Address _____

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):

- Extended testing time (time and a half)
- Screen Reader (software programs that allow blind or visually impaired users to read the text that is displayed on the computer screen with a speech synthesizer or braille display)
- Other special accommodations (please specify):

Applicant Signature: _____

*** This form must be submitted prior to scheduling a formal testing date through ProctorU***



ALPP Documentation of Disability-Related Needs by Qualified Provider

Name _____

Home Address _____

City _____ State _____ Zip _____

Daytime Phone _____

Email Address _____

Date of CLC Certification _____

Location of CLC 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) _____.

(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: _____

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.

******For ALPP office use only******

Approved

Denied

Reason:

Date

Authorized ALPP Representative