ALPP
THE ACADEMY OF
Lactation Policy and Practice

ALPP Special Testing Accommodation Request Form

Advanced Nurse Lactation Consultant (ANLC)

Name ______________________________

Home Address ______________________________

City ______________ State ________ Zip ______________

Daytime Phone ______________________________

Email Address ______________________________

Date of ANLC Certification ______________________________

Location of ANLC 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 - ANLC

PO Box 2170

South Dennis, MA 02660

OR fax to: (508)-833-6070

ALPP
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Lactation Policy
and Practice

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.

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ALPP Documentation of Disability-Related Needs by Qualified Provider

Advanced Lactation Consultant (ANLC)

Name

Home Address

City State Zip

Daytime Phone

Email Address

Date of ANLC Certification

Location of ANLC 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: ____

____.

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PO Box 2170

South Dennis, MA 02660

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.

Updated 3/5/2021

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