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***

Please send to:

Academy of Lactation Policy and Practice

PO Box 2170

South Dennis, MA 02660

OR fax to: 508-833-6070

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:____

____
____.

Please send to:

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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

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