AutoTechnician.org Alternate Testing Accommodations Application and Documentation Form

This page is to be completed by the Diagnosing or Treating Professional

Name: _____

Date: _____

Professional Credentials: _____

Area of Specialty: _____

Mailing Address: _____

City, State/Province, Postal Code: _____, _____, _____

Phone number: (___)_____-_____

Fax Number: (____)_____-_____

Email Address: (optional)_____

Signature: _____

Patient's Name:_____

1. Please identify the patient's specific disabling condition.

Primary Diagnosis:

_____

_____

Secondary Diagnosis:

_____

_____

The legal definition of a disability is a physical or mental impairment that substantially limits a major life activity including but not limited to sight, mobility, hearing, and learning.

2. Does this condition substantially limit the patient? YES (___) or **NO** (___)

This page is to be completed by the Diagnosing or Treating Professional

3. Please check all major life activities that are substantially limited.

____Walking

____Hearing

____Seeing

____Working

____Sleeping

____Caring for Self

____Interacting with others

____Learning (including memory/concentration)

____Performing manual tasks

____Other major life activities – please specify

_____
_____
_____

4. Date of last office visit: _____

5. Original diagnosis date or follow-up date:_____

6. Is this condition: **Permanent** (___) or **Temporary** (___)

If this condition is temporary, how much longer do you expect it to last?_____

7. Please identify how this impairment may affect this person's ability to read and respond to a multiple-choice test:

_____
_____
_____

8. Please attach any additional documentation (e.g. condition-specific diagnostic reports, reports of psycho-educational evaluations, treatment plans, etc.) that may help us understand how this person's diagnosed impairment makes him or her disabled under the provisions of the Americans with Disabilities Act (ADA).

This page is to be completed by the test taker

Name:_____

Today's Date: _____

Mailing Address: _____

City, State & Postal Code:_____,_____,_____

Phone number: (___)_____-_____

Email Address (if applicable): _____

Please check each of the accommodations you are requesting.

____**Reader** – Designate the person who will read (or sign) for you:
_____

____**Scribe** – Designate the person who will mark your questions for:
_____

____**Large print format test** (if receiving downloadable or mailed test version).

____**Other – please specify**:
_____
_____
_____

Testing Setting: Please note you are permitted to take this test where it is most convenient and comfortable for you, including your home or place of business. There are no restrictions with time for alternate testing. Our only goal is to provide fair and equal opportunity **registration** into our Membership Directory.

Return completed forms to:

AutoTechnician.org
P.O. Box 25592
Rochester, NY 14625
Fax (585) 385-1074