REQUEST FOR TEST ACCOMODATIONS

The Universal Life Care Planner Certification Board (ULCPCB™) supports the intent of and complies with the Americans with Disabilities Act (ADA). ULCPCB™ will take steps reasonably necessary to make certification accessible to persons with disabilities covered under the ADA. According to the ADA, an individual with a disability is a person who has a physical or mental impairment that substantially limits a major life activity (such as seeing, hearing, learning, reading, concentrating, walking) or a major bodily function (such as neurological, endocrine, or digestive system). The information you provide and any documentation regarding your disability and test accommodations will be held in strict confidence.

All approved test accommodations must maintain the psychometric nature and security of the examination. Accommodations that fundamentally alter the nature or security of the exam will not be granted.

Test Accommodations may be made upon receipt of the Application, examination fee, and a completed and signed Request for Test Accommodations Form. This form must be uploaded with the online application. Applications and accommodation requests must be submitted no later than 8 weeks before you receive the portfolio examination documents. Candidates who do not submit their Test Accommodations Form with their application may not be able to test during their chosen testing period.

Only those requests made and received on the official Request for Test Accommodations Form will be reviewed. Letters from doctors and other healthcare professionals must be accompanied by the official form and will not be accepted without the form. All requests must be made at the time of application. Accommodations cannot be added once portfolio examination documents have been received.

REQUEST FOR TEST ACCOMMODATIONS FORM

This Request for Test Accommodations Form must be completed if you are an individual with a disability covered under the Americans with Disabilities Act (ADA) and would like to request test accommodations. Under the ADA, an individual with a disability is a person who has a physical or mental impairment that substantially limits a major life activity (such as seeing, hearing, learning, reading, concentrating, walking) or a major bodily function (such as the neurological, endocrine, or digestive system). The information you provide and any documentation regarding your disability and test accommodations will be held in strict confidence. This Form MUST be submitted with your application and received at least 8 weeks before you receive the portfolio examination documents. Forms received after your application has been submitted and less than 8 weeks prior to the start of your testing period may result in a delay in processing and your ability to take the portfolio examination during the timeframe you desire. The content and validity of the examination shall not be compromised by these accommodations.

Part I – to be completed by the Candidate

PLEASE TYPE OR PRINT CLEARLY

	Test Accommodations
___________________________________ Name of Examination ___________________________________ Name (Last, First, Middle Initial) ___________________________________ Address ___________________________________ City State Zip Code ___________________________________ Daytime Telephone Number ___________________________________ E-mail Address Have you received the same or similar test accommodations while in an academic setting? NO ______ YES______ If yes, provide the year(s) that you received these accommodations. If no, please explain below. ___________________________________ ___________________________________	I have discussed my Test Accommodations with my qualified healthcare professional and request Test Accommodations as follows: (Check all that apply) Extended time to submit portfolio ☐ 15-day extension ☐ 30-day extension ☐ 45-day extension ☐ Other (please specify number of days) _________ ☐ Other test accommodations (Please be specific) ___________________________________ ___________________________________ ___________________________________

Signed: ____________________________ **Date:** ____________

Candidate Signature

Continue to next page for Part II

REQUEST FOR TEST ACCOMMODATIONS FORM

Part II – Qualified Healthcare Professional Section

This section must be completed by a qualified healthcare professional who is licensed and has expertise in the disability for which these accommodations are sought. The qualified professional must have evaluated the candidate and is familiar with the candidate's condition.

PLEASE TYPE OR PRINT CLEARLY

Professional Documentation

I have evaluated ___________________________________ on ________/____/_____ in
Candidate Name *Month Day Year*

my capacity as a ____.
Professional Title

The candidate discussed with me the nature of the examination to be administrated. It is my opinion that, because of this candidate's disability described below, he/she should receive the test accommodations requested. Please type or print clearly. Description of Disability:
____
____

Diagnosis code(s): ____

Are you licensed to diagnose the disability described in this Form? No _____ Yes _____

Date of disability onset: _______________________________

Major life activity impaired by disability condition: ____

For a diagnosis of generalized anxiety disorder, please provide the additional information

1. Has this person had anxiety for more than 6 months? No___ Yes____
2. Is the anxiety excessive and interferes significantly with psychosocial functioning?
   No___ Yes___
3. Does this person have anxiety about a variety of life events or activities?
   No _____ Yes _____ indicate the number of activities impacted: _______________
4. Is the anxiety associated with 3 or more of the following: restless, easily fatigued, sleep disturbance, difficulty concentrating, irritability, muscle tension? No__ Yes___

Signed: ______________________________Title: ________________________________
Qualified Professional's Name (Print Name): ____
Address: ____
Telephone Number: ___________________________E-mail: ______________________
Date: ____________________________
License #: __________________Type of license: __________________State in which licensed: _________