



Special Accommodation Form

ICNCS Examination

Name

Address

Phone

Email

Date of ICNCS Exam

Candidates with disabilities covered by the Americans with Disabilities Act 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 Accommodations

I am requesting the following testing accommodation(s):

Extended test time

Large print

Wheelchair accessible testing site

Other special accommodation (please detail):

Application Signature: _____

*Form must be submitted 2 weeks prior to testing.

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.

Name

Address

Email

Phone

Date if ICNCS Exam _____

Professional Information

I evaluated _____ on _____.
(Name of applicant) (Date)

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 and Specific Accommodations Requested (attach additional sheets if necessary):

Signature: _____

Title: _____

Organization: _____

License # (if applicable): _____

Phone #: _____

Date: _____

Candidate Instructions: Return this form with a copy of the Special Testing Accommodation Request Form. This form must be submitted 2 weeks prior to the start of the ICNCS Examination.

Form should be mailed to: Newborn Care International | 3403 W Wallcraft Ave. | Tampa, FL 33611