ADA ACCOMMODATION REQUEST FORM

If you have a disability covered by the Americans with Disabilities Act of 1990 (ADA) and would like to request an accommodation in testing, please complete Section 1 below and have an appropriate professional (i.e., education professional, doctor, psychologist, psychiatrist) with current knowledge of your disability complete Section 2 below to certify that your disability requires the requested test accommodation. **This form must be submitted for each examination you wish to take.**

As provided in Section 3 below, please also have this professional attach a letter detailing the specific nature of your disability as it relates to the request and the reasons for requesting the accommodation. The letter must be written on the professional's letterhead, must have an original signature, and must be dated no more than three (3) years prior to this application. (*If you have existing documentation of having the same or similar accommodation provided to you in another testing situation, you may submit such documentation instead of having the Section 3 portion of this form completed.)*

You will receive a letter, separate from your examination confirmation, accepting or denying your request. If you do not receive this letter approximately one week prior to your testing date, please call ICC at 1-888-422-7233 to confirm. **Do not attempt to test until you have received this ADA request confirmation letter.**

If any of the items are not completed and included, your request will not be processed.

SECTION 1 – To be completed by candidate
PLEASE TYPE OR PRINT CLEARLY – ATTACH ADDITIONAL PAGES IF NECESSARY

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ E-mail: _____

For which examination are you requesting assistance? _____

Nature of disability: _____

ADA accommodation requested: _____

_____

By signing below, I attest that the information I have provided on this application is accurate, true, and correct to the best of my knowledge. I agree to and authorize the release of information requested to ICC for use in determining eligibility for the requested accommodation in testing. If the information provided is not sufficient to evaluate the request, I authorize ICC to obtain additional information from the professional who completes the documents on my behalf related to this request and/or those entities who have provided test accommodations in the past. In addition, I authorize that professional and/or entities to provide additional information to ICC if necessary for evaluating the appropriateness of my requested accommodation in testing. I understand that ICC reserves the right to verify any and all information in my application. Therefore, I understand and agree that my failure to provide accurate, true, and correct information shall constitute grounds for rejection of my request for this accommodation in testing.

Signature: _____ Date: _____

Return this completed application to:

International Code Council (ICC) 900 Montclair Road Birmingham, AL 35213-1206 Phone 205-591-1853 or 888-422-7233 www.iccsafe.org

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SECTION 2 – To be completed by healthcare professional
PLEASE TYPE OR PRINT CLEARLY – ATTACH REQUIRED DOCUMENTATION

I have known _____ since _____
(Full name of candidate) (Date)

In my role as a _____.
(Professional title)

I have attached a copy of my professional credentials.

I certify that I have discussed the nature of the test to be administered by the International Code Council (ICC) with the above-named candidate, and it is my opinion that because of this applicant's disability, he/she should be accommodated by providing the following (check all that apply):

_____ Accessible examination site

_____ Separate examination area

_____ Large print examination (specify type size _____)

_____ Taped examination

_____ Reader

_____ Electronic media examination

_____ Sign language interpreter

_____ Scribe/amanuensis

_____ Extended time:

_____ Time-and-a-half

_____ Other time limit (specify time limit _____)

_____ Other (please specify _____)

Name: _____

Signature: _____ Date: _____

Title: _____ License # and State: _____

Phone #: _____ E-mail: _____

ADA ACCOMMODATION REQUEST FORM

SECTION 3 – To be completed by appropriate professional

Please attach a letter detailing the specific nature of the candidate's disability as it relates to the request and the reasons for requesting the accommodation. The letter must be written on your professional letterhead, must have an original signature, and must be dated no more than three (3) years prior to the application. (*If you have existing documentation of having the same or similar accommodation provided to you in another testing situation, you may submit such documentation instead of having this section of this form completed.)*