ADA Test Accommodation Request Form

*Applicant – If requesting test accommodations, this completed form must be included when submitting your Application.

Candidates with disabilities covered by the Americans with Disabilities Act should complete this form and have an appropriate licensed health care provider OR an educational or testing professional familiar with the applicant's disability complete the *Documentation of Requested ADA Accommodations by Qualified Professional* Form (immediately following) to provide sufficient information for NFPA to evaluate the request for test accommodations. The information provided regarding the disability and the need for accommodation in testing will be treated with strict confidentiality.

CANDIDATE INFORMATION

Last Name: _________________________ First Name: __________________ Middle Initial: ____

Address:____

City: _____________________ State: _____ ZIP/Postal Code: ___________ Country:______________

Primary Telephone Number: ___________________________

Preferred Test Date: __________________ Preferred Test Site: _______________________________

TEST ACCOMMODATIONS REQUESTED

Please check the test accommodation(s) being requested: (Check all that apply.)

☐ Wheelchair access
☐ Special seating
☐ Screen reader
☐ Recorder or transcription software
☐ Extended testing time (time and a half) *If different amount is requested, describe in "other"
☐ Separate testing area
☐ Large font size
☐ Other special accommodations (please specify)

____
____

DOCUMENTATION OF REQUESTED ADA ACCOMODATIONS
BY QUALIFIED PROFESSIONAL

*Applicant – If requesting test accommodations, this completed form must be included when submitting your Application.

This document must be completed by a licensed health care provider OR an educational or testing professional familiar with the applicant's disability to provide sufficient information for NFPA to evaluate the request for test accommodations. If additional room is needed to complete this form, please attach an additional page.

PROFESSIONAL DOCUMENTATION

I know ____ (Name of Candidate) in my capacity as a(n) ____ (Professional Title). I have discussed the nature of the test to be administered with the candidate.

Disability covered by ADA Act: ____

Requested Test Accommodations (please list and describe): ____________________________________
____
____

Past Accommodations provided in similar testing situations (please list and describe): ________________
____
____

Signature:____ Date: __________________________

Title: _____________________________________ License No. (if applicable): _____________