*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 ACCOMMODATIONS
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): ________________