

## CASp TEST ACCOMMODATION(S) REQUEST QUESTIONNAIRE

### VOLUNTARY CERTIFIED ACCESS SPECIALIST (CASp) PROGRAM

This form may be completed online and printed. Please read the *ADA Test Accommodation(s) Guidelines for the CASp Examination (03/20/16)*, incorporated by reference, and the *CASp Examination, Certification, and Practice Standards Handbook (02/2016)*, incorporated by reference, before completing this CASp Test Accommodation(s) Request Questionnaire. Candidate information items with an asterisk (\*) are required to be provided.

CANDIDATE INFORMATION				
Title:	<input type="checkbox"/> Mr.	<input type="checkbox"/> Ms.	<input type="checkbox"/> Mrs.	<input type="checkbox"/> Dr.
Name (Last)*	(First)*		(Middle)	
Mailing Address – Street address or PO Box *				
City*	County	State*	ZIP Code *	
Primary Phone*			Secondary Phone	
Email*				

What accommodation(s) appropriate to the disability are you requesting?

ACCOMMODATION REQUEST

---

**CASp TEST ACCOMMODATIONS REQUEST QUESTIONNAIRE**

To document your need for an accommodation as completely as possible, write a personal statement describing your disability and its impact on your ability to take the exam under standard conditions. Please indicate if your disability is permanent.

**PERSONAL STATEMENT**

I certify under penalty of perjury under the laws of the State of California that the information on this application is true and complete to the best of my knowledge. I acknowledge that any false, incomplete, or incorrect statements may result in my disqualification from the certification process or denial of my request for accommodation in taking the CASp examination.

---

SIGNATURE

---

DATE