

Request for Exam Accommodations

If you have a disability covered by the Americans with Disabilities Act (ADA), please complete this form and the Documentation of Disability-Related Needs form on the next page so your accommodations for testing can be processed efficiently. The information you provide and any documentation regarding your disability and need for accommodation in testing will be treated with strict confidentiality. **Please submit completed form 2 to 3 weeks prior to your anticipated exam date.**

Candidate Information

AACN Customer #: _____ Requested Testing Center: _____

Name: _____
Last First MI Maiden

Mailing Address: _____
City State Zip

Daytime Phone Number: _____

Exam Accommodations

I request accommodations for the _____ certification exam.

Please provide (check all that apply):

- Seating or other physical accommodations
- Scribe/recorder
- Reader
- Sign language interpreter
- Reduced distraction environment
- Extended testing time (*check one*) time and a half double time
- Other special accommodations (*please specify*)

Comments: _____

Signed: _____ Date: _____

Submit this form with your exam application via ONE of the following methods.

- **mail:** AACN Certification Corporation, 27071 Aliso Creek Road, Aliso Viejo, CA 92656-3399
- **email:** info@aacn.org
- **fax:** 949-362-2020

For questions, call AACN Customer Care at 800-899-2226.

Documentation of Disability-Related Needs

Please have this section completed by an appropriate qualified professional (e.g., education professional, physician, psychologist, psychiatrist) to ensure that our testing vendor, PSI Services, is able to provide the required accommodations.

Professional Documentation

I have known _____ since ____ / ____ / ____ in my capacity as a
Exam Candidate Name mm dd yy

Professional Title

The candidate discussed with me the nature of the exam to be administered. It is my opinion that, because of this candidate's disability described below, he/she should be accommodated by providing the arrangements listed below and/or on the attached.

Description of Disability: _____

Signed: _____ Date: _____

Printed Name: _____

Address: _____

Phone Number: _____ Email: _____

License # (if applicable): _____

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