Special Accommodations Request

Date _____

Name _____

Accommodations may be available for individuals with documented disabilities pursuant to the Americans with Disabilities Act. MedCA provides reasonable testing accommodations to candidates whose documented disabilities or other qualifying medical conditions hinder their ability to take the examination under standard conditions. To be considered for special accommodations, please complete the Special Accommodations Request Form. Decisions will be made on a case-by-case basis in accordance with the law and the information submitted.

Candidates will be notified in writing of the decision regarding their request for an accommodation. Candidates who receive a testing accommodation are subject to the same policies as other exam takers. MedCA reserves the right to make a final judgment regarding special accommodations.

Instructions

1. Attach a letter from a physician or other healthcare professional qualified to diagnose the disability or medical condition and render an opinion as to the need for an accommodation. The letter must be dated within one year of the anticipated date of your exam. The letter must include the following:
    a. The specific disability/diagnosis.
    b. A brief explanation of how this condition limits the candidate's ability to take the exam under standard conditions.
    c. Accommodations required. The accommodations should be adequate without creating an unfair advantage.
2. Attach the completed Special Accommodations Request Form on the following page.
3. Submit the form and all documentation to MedCA via fax, email or mail:

Fax: 516-442-3222 Email: info@medcainc.com Mail: MedCA, Inc.
376 S. Bayview Ave.
Freeport, NY 11520

Special Accommodations Request Form (To be completed by the candidate)

Date _____

Name _____

Address _____

_____

Daytime Phone _____

Email Address _____

Name of exam for which I am
seeking accommodations_____

Description of
Disability(ies)_____

Accommodations Requested _____

Under penalty of perjury, I declare that the aforementioned representations that I have made in this Request for Accommodations and any supporting documentation are true to the best of my knowledge. I understand that false information may result in the denial or revocation of accommodations and/or certification. I hereby certify that I personally completed this form and that I may be asked to verify this information at any time. I understand that MedCA reserves the right to make additional inquiries regarding my disability(ies) before rendering a decision.

If clarification or further information is required, I authorize MedCA to communicate with the professional(s) who diagnosed the disability and the professional(s) who provided information related to my Request for Accommodations. I understand that MedCA may request additional documentation from the persons referenced above and/or me. I also authorize MedCA to release this information to a professional chosen by MedCA for the purpose of conducting an independent evaluation of the requested accommodations. I acknowledge that these processes may require extra time for the accommodations to be granted.

_____ _____

Candidate's Signature Date