# Section 9: Forms

## Special Accommodations Request Form

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. The information you provide, and any documentation regarding your disability and special accommodation, will be treated with strict confidentiality and will not be shared with any source, without your express written permission, except for BICC.

Please submit completed form to: leadership@behavioralinterventioncertification.org

### Applicant Information

| First Name: ____________________________ | MI: ____ | Last Name: ____________________________ |
| Address: ____________________________________________________________ |
| City: ____________________________ | State: __________ | Zip Code: ________ |
| Phone: ____________________________ | Email: ____________________________ |

### Special Accommodations

Please provide (check all that apply)

- [ ] Accessible Testing Site
- [ ] Screen Magnifier (Large Font)
- [ ] Separate Testing Room
- [ ] Reader Required for Learning Disability
- [ ] Extended Testing Time
- [ ] Reader Required for Visual Disability
- [ ] Other special accommodation: ____________________________________________

Comments: ______________________________________________________________
__________________________________________________________

Applicant’s Signature: ____________________________ | Date: ____________________________
Documentation of Disability-Related Needs Form

Candidates for the BCAT certification examination who have a learning, psychological, or other disability that requires accommodation during testing must provide a written disability report prepared by an appropriately qualified, licensed health care professional (e.g. physician, nurse practitioner, psychologist, psychiatrist). The information you provide, and any documentation regarding your disability and special accommodation request, will be treated with strict confidentiality.

Please submit completed form to: leadership@behavioralinterventioncertification.org

LICENSED HEALTHCARE PROVIDER DOCUMENTATION

I have known ______________________________________ since ____/____/___________

Test applicant

in my capacity as a __________________________________________

Professional Title

SPECIAL ACCOMMODATIONS

Given the nature of the test to be taken by the above-named candidate, it is my opinion that he/she should be accommodated by providing the following special arrangements:

Check all that apply:

○ Accessible testing site ○ Screen Magnifier (Large Font)
○ Separate testing room ○ Reader Required for Learning Disability
○ Extended testing time ○ Reader Required for Visual Disability
○ Other special accommodation: __________________________________________

Signature: ___________________________ Date: ___________________________

Title: ___________________________ License ___________________________

(if applicable)