



*prove yourself.*

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# Disabilities and the Law

## ADA, 504 and IDEA

- ADA, 1990, prohibits discrimination in employment, or public services on the basis of a disability
- Disability must substantially limit one or more of life's activities
- 504, 1973, prohibits discriminating due to disability in programs receiving federal funds

*prove yourself.*

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# Disabilities and the Law

## ADA, 504 and IDEA

- Disability must be documented by persons knowledgeable of the disability
- IDEA, Federal Government guarantees special education services for children with disabilities
- Accommodations must be reasonable

# Accommodation Forms

~~L-15~~

~~SA-001~~

# Request for Testing Accommodation Forms

- Checklist used for candidates and examiners
- Emotional/Mental Health
- Physical/Chronic Health
- Attention-Deficit/Hyperactivity Disorder
- Learning and Other Cognitive Disabilities
- Testing Accommodations Appeal Form

**Request for Testing Accommodations**  
Physical/Chronic Health Disability

To be completed by Chief Examiner  
Candidate's Last 4 SSN/SIN

**Section 1: To be completed by GED Candidate**

Fill in this section completely and sign the release of information statement. Make certain all sections are completed by the appropriate professional before you return the form to the Chief Examiner at your local testing center. The Chief Examiner will review the form and let you know if additional information is required.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
Social Security or Social Insurance Number \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State/Province/Territory \_\_\_\_\_ ZIP/Postal Code \_\_\_\_\_  
Phone Number: \_\_\_\_\_

**Release of information:** If you are under 18 years of age, your parent or guardian's signature is also required.

I grant permission to school officials and my healthcare provider(s) to release my education-related records and/or my medical or psychological records to the GED Testing Service and its designees in connection with my request for testing accommodations.

Candidate's Signature \_\_\_\_\_ Parent or Guardian's Signature (if appropriate) \_\_\_\_\_ Date \_\_\_\_\_

**Section 2: To be completed by GED Chief Examiner**

Please review the form to be certain all sections have been completed. Record the last four digits of the candidate's SSN/SIN in the top right corner of each page of this form. Missing information may delay the review of the candidate's request. Sign and date the form before sending it to your GED Administrator.

Chief Examiner Name \_\_\_\_\_ 10-Digit Center ID #: \_\_\_\_\_  
Center Name \_\_\_\_\_  
Phone Number: \_\_\_\_\_ FAX Number: \_\_\_\_\_  
E-mail \_\_\_\_\_  
I have reviewed this application and confirm that it is complete.

GED Chief Examiner's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Section 3: To be completed by Professional**

This section must be completed by the professional diagnostician. Alternatively, an advocate from the professional diagnostician's report if the professional is unavailable or documentation is currently on file with a candidate's school district. An advocate is someone other than the professional requesting testing accommodations. The professional's report must indicate certification assessment tests must include a clear diagnosis and provide information on current candidate's ability to take the tests under standard conditions, so that the rationale properly evaluated.

Please indicate your role:  Professional Diagnostician  Advocate

Name of Professional Making Diagnosis (please print): \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Date of Assessment: \_\_\_\_/\_\_\_\_/\_\_\_\_  
License or Certification: \_\_\_\_\_ Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
State/Province/Territory: \_\_\_\_\_ Number: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Name of Advocate (please print): \_\_\_\_\_  
Relationship to Candidate (please print): \_\_\_\_\_  
Phone Number: \_\_\_\_\_

Professional Making Diagnosis or Advocate's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

PCH - page 1 of 3

**Request for Testing Accommodations**  
Attention-Deficit/Hyperactivity Disorder

To be completed by Chief Examiner  
Candidate's Last 4 SSN/SIN

**Section 1: To be completed by GED Candidate**

Fill in this section completely and sign the release of information statement. Make certain all sections are completed by the appropriate professional before you return the form to the Chief Examiner at your local testing center. The Chief Examiner will review the form and let you know if additional information is required.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
Social Security or Social Insurance Number \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State/Province/Territory \_\_\_\_\_ ZIP/Postal Code \_\_\_\_\_  
Phone Number: \_\_\_\_\_

**Release of information:** If you are under 18 years of age, your parent or guardian's signature is also required.

I grant permission to school officials and my healthcare provider(s) to release my education-related records and/or my medical or psychological records to the GED Testing Service and its designees in connection with my request for testing accommodations.

Candidate's Signature \_\_\_\_\_ Parent or Guardian's Signature (if appropriate) \_\_\_\_\_ Date \_\_\_\_\_

**Section 2: To be completed by GED Chief Examiner**

Please review the form to be certain all sections have been completed. Record the last four digits of the candidate's SSN/SIN in the top right corner of each page of this form. Missing information may delay the review of the candidate's request. Sign and date the form before sending it to your GED Administrator.

Chief Examiner Name \_\_\_\_\_ 10-Digit Center ID #: \_\_\_\_\_  
Center Name \_\_\_\_\_  
Phone Number: \_\_\_\_\_ FAX Number: \_\_\_\_\_  
E-mail \_\_\_\_\_  
I have reviewed this application and confirm that it is complete.

GED Chief Examiner's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Section 3: To be completed by Professional Diagnostician or Advocate**

This section must be completed by the professional diagnostician. Alternatively, an advocate may complete this section using information from the professional diagnostician's report if the professional is unavailable or documentation is currently on file with a candidate's school district. An advocate is someone other than the professional diagnostician who helps the candidate request testing accommodations. The professional's report must indicate certification or licensure. Documentation and assessment tests must include a clear diagnosis and provide information on current functional limitations that might affect the candidate's ability to take the tests under standard conditions, so that the rationale for the requested accommodation can be properly evaluated. Documentation will be reviewed a sufficient extent if it has been completed within the last 3 years. However, older documentation will be considered if that is all that the candidate can provide without undue burden or expense.

Please indicate your role:  Professional Diagnostician  Advocate

Name of Professional Making Diagnosis (please print): \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Date of Assessment: \_\_\_\_/\_\_\_\_/\_\_\_\_  
License or Certification: \_\_\_\_\_ Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
State/Province/Territory: \_\_\_\_\_ Number: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Name of Advocate (please print): \_\_\_\_\_  
Relationship to Candidate (please print): \_\_\_\_\_  
Phone Number: \_\_\_\_\_

Professional Making Diagnosis or Advocate's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

ADDADHD - page 1 of 4

**Request for Testing Accommodations**  
Emotional/Mental Health

To be completed by Chief Examiner  
Candidate's Last 4 SSN/SIN

**Section 1: To be completed by GED Candidate**

Fill in this section completely and sign the release of information statement. Make certain all sections are completed by the appropriate professional before you return the form to the Chief Examiner at your local testing center. The Chief Examiner will review the form and let you know if additional information is required.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
Social Security or Social Insurance Number \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State/Province/Territory \_\_\_\_\_ ZIP/Postal Code \_\_\_\_\_  
Phone Number: \_\_\_\_\_

**Release of information:** If you are under 18 years of age, your parent or guardian's signature is also required.

I grant permission to school officials and my healthcare provider(s) to release my education-related records and/or my medical or psychological records to the GED Testing Service and its designees in connection with my request for testing accommodations.

Candidate's Signature \_\_\_\_\_ Parent or Guardian's Signature (if appropriate) \_\_\_\_\_ Date \_\_\_\_\_

**Section 2: To be completed by GED Chief Examiner**

Please review the form to be certain all sections have been completed. Record the last four digits of the candidate's SSN/SIN in the top right corner of each page of this form. Missing information may delay the review of the candidate's request. Sign and date the form before sending it to your GED Administrator.

Chief Examiner Name \_\_\_\_\_ 10-Digit Center ID #: \_\_\_\_\_  
Center Name \_\_\_\_\_  
Phone Number: \_\_\_\_\_ FAX Number: \_\_\_\_\_  
E-mail \_\_\_\_\_  
I have reviewed this application and confirm that it is complete.

GED Chief Examiner's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Section 3: To be completed by Professional**

This section must be completed by the professional diagnostician. Alternatively, an advocate from the professional diagnostician's report if the professional is unavailable or documentation is currently on file with a candidate's school district. An advocate is someone other than the professional requesting testing accommodations. The professional's report must indicate certification assessment tests must include a clear diagnosis and provide information on current candidate's ability to take the tests under standard conditions, so that the rationale properly evaluated. Documentation will be reviewed a sufficient extent if it has been completed within the last 3 years. However, older documentation will be considered if that is all that the candidate can provide without undue burden or expense.

Please indicate your role:  Professional Diagnostician  Advocate

Name of Professional Making Diagnosis (please print): \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Date of Assessment: \_\_\_\_/\_\_\_\_/\_\_\_\_  
License or Certification: \_\_\_\_\_ Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
State/Province/Territory: \_\_\_\_\_ Number: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Name of Advocate (please print): \_\_\_\_\_  
Relationship to Candidate (please print): \_\_\_\_\_  
Phone Number: \_\_\_\_\_

Professional Making Diagnosis or Advocate's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

EMH - page 1 of 3

**Request for Testing Accommodations**  
Learning and Other Cognitive Disabilities

To be completed by Chief Examiner  
Candidate's Last 4 SSN/SIN

**Section 1: To be completed by GED Candidate**

Fill in this section completely and sign the release of information statement. Make certain all sections are completed by the appropriate professional before you return the form to the Chief Examiner at your local testing center. The Chief Examiner will review the form and let you know if additional information is required.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
Social Security or Social Insurance Number \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State/Province/Territory \_\_\_\_\_ ZIP/Postal Code \_\_\_\_\_  
Phone Number: \_\_\_\_\_

**Release of information:** If you are under 18 years of age, your parent or guardian's signature is also required.

I grant permission to school officials and my healthcare provider(s) to release my education-related records and/or my medical or psychological records to the GED Testing Service and its designees in connection with my request for testing accommodations.

Candidate's Signature \_\_\_\_\_ Parent or Guardian's Signature (if appropriate) \_\_\_\_\_ Date \_\_\_\_\_

**Section 2: To be completed by GED Chief Examiner**

Please review the form to be certain all sections have been completed. Record the last four digits of the candidate's SSN/SIN in the top right corner of each page of this form. Missing information may delay the review of the candidate's request. Sign and date the form before sending it to your GED Administrator.

Chief Examiner Name \_\_\_\_\_ 10-Digit Center ID #: \_\_\_\_\_  
Center Name \_\_\_\_\_  
Phone Number: \_\_\_\_\_ FAX Number: \_\_\_\_\_  
E-mail \_\_\_\_\_  
I have reviewed this application and confirm that it is complete.

GED Chief Examiner's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Section 3: To be completed by Professional Diagnostician or Advocate**

This section must be completed by the professional diagnostician. Alternatively, an advocate may complete this section using information from the professional diagnostician's report if the professional is unavailable or documentation is currently on file with a candidate's school district. An advocate is someone other than the professional diagnostician who helps the candidate request testing accommodations. The professional's report must indicate certification or licensure. Documentation and assessment tests must include a clear diagnosis and provide information on current functional limitations that might affect the candidate's ability to take the tests under standard conditions, so that the rationale for the requested accommodation can be properly evaluated. Documentation will be reviewed a sufficient extent if it has been completed within the last 3 years. However, older documentation will be considered if that is all that the candidate can provide without undue burden or expense.

Please indicate your role:  Professional Diagnostician  Advocate

Name of Professional Making Diagnosis (please print): \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Date of Assessment: \_\_\_\_/\_\_\_\_/\_\_\_\_  
License or Certification: \_\_\_\_\_ Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
State/Province/Territory: \_\_\_\_\_ Number: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Name of Advocate (please print): \_\_\_\_\_  
Relationship to Candidate (please print): \_\_\_\_\_  
Phone Number: \_\_\_\_\_

Professional Making Diagnosis or Advocate's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

LD - page 1 of 8

# Developing the Forms

- Original forms were unveiled at the 2004 GED Administrators' Conference
- Ad-hoc Committee (disability specialist, testing professionals, GED Administrators, and GED staff)
- Legal Assistance (USDOE, Office for Civil Rights, and Fulbright & Jaworski)
- Pilot with Examiners in Hawaii and Missouri

# Implementing the Forms

- Request for Accommodations Forms were sent to each jurisdictional administrator in “.pdf” format
- Informational conference calls to GED Administrators were conducted
- Conducted a two day training for jurisdictional Administrators on providing a first tier evaluation using the new forms

# Implementing the Forms

- All forms will be placed on our website at [www.gedtest.org](http://www.gedtest.org) and can be downloaded by the Examiner, Candidate or Advocate.
- Forms will be disseminated via CD at the GED Administrators' - July 2005

# Who is an advocate?

An adult who helps the GED candidate when he/she:

- physically can not complete the form(s)
- is not sure how to complete the form
- is unable to get the form completed by a diagnosing professional
- has difficulty following through on a multi-step process.

## If the student has a copy of the report, then, an advocate ...

- can transcribe all the information requested onto the form (from originally signed report)
- attach a copy of the report to the accommodation request
- complete the advocate information as requested in section 3.

# What if...

- The diagnosing professional is no longer available due to retirement, a move, etc. AND the student has a copy of the report?


OR

- Older documentation is all the candidate can provide?

# All Forms

## Section 1

The candidate must sign the application. If under eighteen (18) years of age, the signature of a parent or legal guardian must be provided.

 8051	<b>Request for Testing Accommodations</b> <b>Learning and Other Cognitive Disabilities</b>	To be completed by Chief Examiners _____ Candidate's Last 4 SSN/SIN
<b>Section 1: To be completed by GED Candidate</b>		
Fill in this section completely and sign the release of information statement. Make certain all sections are completed by the appropriate professional before you return the form to the Chief Examiner at your local testing center. The Chief Examiner will review the form and let you know if additional information is required.		
Last Name: _____ First Name: _____		
Social Security or Social Insurance Number: _____ Birth Date: <u>   </u> / <u>   </u> / <u>   </u> Age: _____ <small>MM DD YYYY</small>		
Address: _____		
City: _____ State/Province/Territory: _____ ZIP/Postal Code: _____		
Phone Number: ( _____ ) _____ - _____		
<b>Release of information:</b> If you are under 18 years of age, your parent or guardian's signature is also required.		
I grant permission to school officials and my healthcare provider(s) to release my education-related records and/or my medical or psychological records to the GED Testing Service and its designees in connection with my request for testing accommodations.		
_____	_____	_____
<i>Candidate's Signature</i>	<i>Parent or Guardian's Signature (if appropriate)</i>	<i>Date</i>

## Every request for testing accommodations

*Requires candidate or parent/guardian to sign statement authorizing release of psychological or medical information*

**Release of Information:** I grant permission to release my medical or psychological records to Testing Service and its designees to document my request for accommodation. If the candidate is under 18 years of age, a parent or guardian's signature is also required.

*Candidate's Signature*

*Parent or Guardian's Signature (if appropriate)*

# All Forms

## Section 2

### Section 2: To be completed by GED Chief Examiner

Please review the form to be certain all sections have been completed. Record the last four digits of the candidate's SSN/SIN in the top right corner of each page of this form. Missing information may delay the review of the candidate's request. Sign and date the form before sending it to your GED Administrator.

Chief Examiner Name: \_\_\_\_\_ 10-Digit Center ID #: \_\_\_\_\_

Center Name: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ FAX Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

E-mail: \_\_\_\_\_

I have reviewed this application and confirm that it is complete.

\_\_\_\_\_  
*GED Chief Examiner's Signature*

\_\_\_\_\_  
*Date*

The Chief Examiner must complete and sign Section 2 asserting the application is complete otherwise it will be returned by the GED Administrator.

# All Forms

## Section 4

8051	<b>Request for Testing Accommodations Learning and Other Cognitive Disabilities</b>	To be completed by Chief Examiners Candidate's Last 4 SSN/SIN
<b>Section 4: To be completed by GED Administrator</b>		
<p>This section should be completed by the GED Administrator after reviewing the request for accommodations to document the outcome of the review.</p>		
<p><input type="checkbox"/> Approved For:</p> <p><input type="checkbox"/> Extended Time (please specify): <input type="checkbox"/> 1-1/2 times    <input type="checkbox"/> 2 times    <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> Audiocassette (tone-indexed) (requires extended testing time, generally double time) <input type="checkbox"/> 2 times    <input type="checkbox"/> Other: _____</p> <p><i>The use of this accommodation requires practice. Candidates should have an opportunity to practice using an Official GED Practice Test-Audiocassette Version prior to scheduled testing date.</i></p> <p><input type="checkbox"/> Braille</p> <p><input type="checkbox"/> Scribe</p> <p><input type="checkbox"/> Calculator for Part II</p> <p><input type="checkbox"/> Talking Calculator for Entire Mathematics Test</p> <p><input type="checkbox"/> Private Room</p> <p><input type="checkbox"/> Supervised Breaks (specify in minutes): Uninterrupted testing time: _____ minutes, break time: _____ minutes</p> <p><input type="checkbox"/> Other: _____</p>		

Section 4 is completed by the  
Jurisdictional Administrator

# All Forms

## Section 4

Returned for more information.

Date Returned:      /      /       
MM DD YYYY

Reasons for returning request:

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Request forwarded to GEDTS for review (explain reasons below.)

Date Forwarded:      /      /       
MM DD YYYY

Reasons for forwarding request to GEDTS for review:

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\_\_\_\_\_  
*GED Administrator's Signature*

\_\_\_\_\_  
*Telephone Number*

\_\_\_\_\_  
*Date*

*prove yourself.*

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# Emotional & Mental Health

## Section 3: To be completed by Professional Diagnostician or Advocate

This section must be completed by the professional diagnostician. Alternatively, an advocate may complete this section using information from the professional diagnostician's report if the professional is unavailable or documentation is currently on file with a candidate's school district. An advocate is someone other than the professional diagnostician who helps the candidate request testing accommodations. The professional's report must indicate certification or licensure. Documentation and assessment tests must include a clear diagnosis and provide information on current functional limitations that might affect the candidate's ability to take the tests under standard conditions, so that the rationale for the requested accommodation can be properly evaluated. *Documentation will be viewed as sufficiently current if it has been completed within the last 6 months. However, older documentation will be considered if that is all that the candidate can provide without undue burden or expense.*

Please indicate your role:  Professional Diagnostician  Advocate

Name of Professional Making Diagnosis (please print): \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Date of Assessment: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

Licensure or Certification: Expiration Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
State/Province/Territory: \_\_\_\_\_ Number: \_\_\_\_\_ Specialty: \_\_\_\_\_

Name of Advocate (please print): \_\_\_\_\_

Relationship to Candidate (please print): \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Professional Making Diagnosis or Advocate's Signature: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

Documentation on file with the candidates' school district can be transferred onto this form by an advocate

## Section 3: To be completed by Professional Diagnostician or Advocate

This section must be completed by the professional diagnostician. Alternatively, an advocate may complete this section using information from the professional diagnostician's report if the professional is unavailable or documentation is currently on file with a candidate's school district. An advocate is someone other than the professional diagnostician who helps the candidate request testing accommodations. The professional's report must indicate certification or licensure. Documentation and assessment tests must include a clear diagnosis and provide information on current functional limitations that might affect the candidate's ability to take the tests under standard conditions, so that the rationale for the requested accommodation can be properly evaluated. *Documentation will be viewed as sufficiently current if it has been completed within the last 6 months. However, older documentation will be considered if that is all that the candidate can provide without undue burden or expense.*

Please indicate your role:  Professional Diagnostician  Advocate

Name of Professional Making Diagnosis (please print): \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Date of Assessment: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

Licensure or Certification: Expiration Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
State/Province/Territory: \_\_\_\_\_ Number: \_\_\_\_\_ Specialty: \_\_\_\_\_

Name of Advocate (please print): \_\_\_\_\_

Relationship to Candidate (please print): \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Professional Making Diagnosis or Advocate's Signature: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

The specialty of the professional is important. The professional diagnostician must be qualified to diagnose the disability.

# EMH

## Section 3A

A letter must be included on official letterhead signed by the professional which list the DSM IV Code, a specific diagnosis, the functional limitations and the rationale for accommodations

### Section 3A: Emotional/Mental Health Impairment

To be completed by the professional diagnostician or person helping you complete this form.

To request accommodations for an Emotional/Mental Health disability, the current level of impairment and resulting functional limitations must be clearly documented, as well as any history that can be provided. Documentation should also state a specific recommendation(s) for accommodations and the accompanying rationale.

Documentation must include a letter on official letterhead, signed by a certifying professional who specializes in the diagnosis of the disability, and providing supporting documentation of this disability.

Supporting documentation on professional diagnostician's letterhead attached. (Required.)

DSM-IV Code: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Condition:

Functional Limitations: \_\_\_\_\_

Recommended accommodation(s): \_\_\_\_\_

Rationale for accommodation(s): \_\_\_\_\_

The professional diagnostician must identify all necessary accommodations.

## Section 3B: Requested Accommodations

Please identify those accommodations that support the diagnosed disability.

Extended Time (please specify):  1-1/2times  2times  Other: \_\_\_\_\_

Audiocassette (tone-indexed) (requires extended testing time, generally double time)

2times  Other: \_\_\_\_\_

*The use of this accommodation requires practice. Candidates should have an opportunity to practice using an Official GED Practice Test, Audiocassette Version prior to scheduled testing date.*

Braille

Scribe

Calculator for Part II

Talking Calculator for Entire Mathematics Test

Private Room

Supervised Breaks (specify in minutes):

Uninterrupted testing time: \_\_\_\_\_ minutes, break time: \_\_\_\_\_ minutes

Other: \_\_\_\_\_

## Section 3C: Other Information and Supporting Documents

This section may be completed by the candidate or by his or her certifying professional or advocate. Provide any additional information you wish to be considered when this request for accommodations is reviewed.

General Educational Development (GED) Testing Service will not discriminate against candidates for testing on the basis of any legally protected characteristic, including, but not limited to, race, color, religion, sex, sexual orientation, pregnancy, marital status, physical or mental disability, age, veteran status, and national origin.

Provide any additional information that may assist with the approval of the request.



# PCH

## Section 3

### Section 3: To be completed by Professional Diagnostician or Advocate

This section must be completed by the professional diagnostician. Alternatively, an advocate may complete this section using information from the professional diagnostician's report if the professional is unavailable or documentation is currently on file with a candidate's school district. An advocate is someone other than the professional diagnostician who helps the candidate request testing accommodations. The professional's report must indicate certification or licensure. Documentation and assessment tests must include a clear diagnosis and provide information on current functional limitations that might affect the candidate's ability to take the tests under standard conditions, so that the rationale for the requested accommodation can be properly evaluated.

Please indicate your role:  Professional Diagnostician  Advocate

Name of Professional Making Diagnosis (please print): \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Date of Assessment: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MI DO YYYY

Licensure or Certification: Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
State/Province/Territory: \_\_\_\_ Number: \_\_\_\_ Specialty: \_\_\_\_\_

Name of Advocate (please print): \_\_\_\_\_

Relationship to Candidate (please print): \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Professional Making Diagnosis or Advocate's Signature: \_\_\_\_\_

- Documentation on file with the candidates' school district can be transferred onto this form by an advocate
- The specialty of the professional is important. The professional diagnostician must be qualified to diagnose the disability.

# PCH

## Section 3A

A letter must be included on official letterhead signed by the professional which list the DSM IV Code, a specific diagnosis, the functional limitations and the rationale for accommodations

*Examples of conditions listed as **Other** could be Diabetes, Cancer, HIV, etc.*

### Section 3A: Physical/Chronic Health Disability

To request accommodations for a Physical/Chronic Health disability, the current level of impairment and resulting functional limitations must be clearly documented, as well as any history that can be provided.

**Documentation must include a letter on official letterhead, signed by a qualified professional, stating the diagnosed disability and providing supporting documentation of this disability.**

Documentation for those candidates that have a Physical/Chronic Health disability should reflect current functional limitations.

Supporting documentation on professional diagnostician's letterhead attached. (Required.)

**Condition:**

Visual Impairment - Describe: \_\_\_\_\_

Hearing Impairment - Describe: \_\_\_\_\_

Mobility Impairment - Describe: \_\_\_\_\_

Other Impairment - Describe: \_\_\_\_\_

Functional Limitations: \_\_\_\_\_

Recommended Accommodations: \_\_\_\_\_

Rationale for Accommodations: \_\_\_\_\_

Individuals with physical disabilities should include under “Other” those accommodations that are not listed.

## Section 3B: Requested Accommodations

Please identify those accommodations that support the diagnosed disability.

Extended Time (please specify):  1-1/2 times  2 times  Other: \_\_\_\_\_

Audiocassette (tone-indexed) (requires extended testing time, generally double time)

2 times  Other: \_\_\_\_\_

*The use of this accommodation requires practice. Candidates should have an opportunity to practice using an Official GED Practice Test, Audiocassette Version prior to the scheduled testing date.*

Braille

Scribe

Calculator for Part II

Talking Calculator for Entire Mathematics Test

Private Room

Supervised Breaks (specify in minutes):

Uninterrupted testing time: \_\_\_\_\_ minutes, break time: \_\_\_\_\_ minutes

Other: \_\_\_\_\_

General Educational Development (GED) Testing Service will not discriminate against candidates for testing on the basis of any legally protected characteristic, including, but not limited to, race, color, religion, sex, sexual orientation, pregnancy, marital status, physical or mental disability, age, veteran status, and national origin.

*prove yourself.*

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# **Attention Deficit --- Hyperactivity Disorder**

# AD/HD

## Section 3

### Section 3: To be completed by Professional Diagnostician or Advocate

This section must be completed by the professional diagnostician. Alternatively, an advocate may complete this section using information from the professional diagnostician's report if the professional is unavailable or documentation is currently on file with a candidate's school district. An advocate is someone other than the professional diagnostician who helps the candidate request testing accommodations. The professional's report must indicate certification or licensure. Documentation and assessment tests must include a clear diagnosis and provide information on current functional limitations that might affect the candidate's ability to take the tests under standard conditions, so that the rationale for the requested accommodation can be properly evaluated. *Documentation will be viewed as sufficiently current if it has been completed within the last 3 years.* However, older documentation will be considered if that is all that the candidate can provide without undue burden or expense.

Please indicate your role:  Professional Diagnostician  Advocate

Name of Professional Making Diagnosis (please print): \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Date of Assessment: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

Licensure or Certification: Expiration Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
State/Province/Territory: \_\_\_\_ Number: \_\_\_\_ Specialty: \_\_\_\_

Name of Advocate (please print): \_\_\_\_\_

Relationship to Candidate (please print): \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Professional Making Diagnosis or Advocate's Signature: \_\_\_\_\_

- Check boxes for both the professional and the advocate, one should be selected
- Only certain professionals can diagnose ADD/HD, therefore we are seeking the specialty

# AD/HD

## Section 3

### Section 3: To be completed by Professional Diagnostician or Advocate

This section must be completed by the professional diagnostician. Alternatively, an advocate may complete this section using information from the professional diagnostician's report if the professional is unavailable or documentation is currently on file with a candidate's school district. An advocate is someone other than the professional diagnostician who helps the candidate request testing accommodations. The professional's report must indicate certification or licensure. Documentation and assessment tests must include a clear diagnosis and provide information on current functional limitations that might affect the candidate's ability to take the tests under standard conditions, so that the rationale for the requested accommodation can be properly evaluated. *Documentation will be viewed as sufficiently current if it has been completed within the last 3 years.* However, older documentation will be considered if that is all that the candidate can provide without undue burden or expense.

Please indicate your role:  Professional Diagnostician  Advocate

Name of Professional Making Diagnosis (please print): \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Date of Assessment: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

Licensure or Certification: Expiration Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
State/Province/Territory: \_\_\_\_ Number: \_\_\_\_ Specialty: \_\_\_\_

Name of Advocate (please print): \_\_\_\_\_

Relationship to Candidate (please print): \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Professional Making Diagnosis or Advocate's Signature: \_\_\_\_\_

ADD/ADHD • page 1 of 4

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY


- We will accept documentation from the secondary setting which can be transferred onto the forms.
- Documentation is current if done within 3 years.
- Older documentation will be considered so as not to provide undue burden or expense to the candidate.

# AD/HD

## Section 3A-1

A letter on official letterhead must include

- A clear diagnosis using a DSM-IV code
- Functional limitation of the candidate
- Rationale for requested accommodations

	<b>Request for Testing Accommodations</b> Attention-Deficit/Hyperactivity Disorder	To be completed by Chief Examiners. _____ Candidate's Last 4 SSN/SIN
12475		
<b>Section 3A: Attention-Deficit/Hyperactivity Disorder</b>		
<b>Attention-Deficit/Hyperactivity Disorder (ADHD)</b>		
<p>To request accommodations for ADHD, the current level of impairment and resulting functional limitations must be clearly documented, as well as the history of those impairments and limitations. <b>Documentation must include a letter on official letterhead, signed by a psychiatrist, medical doctor, or psychologist who specializes in the diagnosis of ADHD, stating the diagnosis of ADHD and providing supporting diagnostic evidence of this disability.</b></p>		
<p>Diagnostic evidence may include a developmental history that defines symptom onset, as well as the results from a specific test of attention such as the TOVA Gordon Diagnostic Battery or the CPT (Conners' Continuous Performance Test).</p>		
<p>Information presented must clearly document how the ADHD substantially limits the candidate's current ability to take the GED Tests under standard conditions, and identify the accommodations that are requested in light of those limitations. Further, the documentation must confirm that the ADHD symptoms are not due to other emotional/mental health factors. A DSM-IV diagnosis must be included with the certifying professional's or advocate's signature attesting to the diagnosis of ADHD.</p>		
<input type="checkbox"/> Supporting documentation on professional diagnostician's letterhead attached. (Required.)		

# AD/HD

## Section 3

**DSM-IV Diagnosis Code:** Indicate all that apply.

- 314.01 Attention-Deficit/Hyperactivity Disorder Combined Type      .   .   .
- 314.00 Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type      .   .
- 314.01 Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulse Type      .   .
- 314.9 Attention-Deficit/Hyperactivity Disorder, Not Otherwise Specified

Functional Limitation(s): \_\_\_\_\_

Recommended Accommodation(s): \_\_\_\_\_

Rationale for Accommodation(s): \_\_\_\_\_

AD/HD

# Section 3B

## Section 3B: Requested Accommodations

Please identify those accommodations that support the diagnosed disability.

Extended Time (please specify):  1-1/2times  2times  Other: \_\_\_\_\_

Audiocassette (tone-indexed) (requires extended testing time, generally double time)

2 times  Other: \_\_\_\_\_

*The use of this accommodation requires practice. Candidates should have an opportunity to practice using an Official GED Practice Test, Audiocassette Version prior to the scheduled testing date.*

Braille

Scribe

Calculator for Part II

Talking Calculator for Entire Mathematics Test

Private Room

Supervised Breaks (specify in minutes):

Uninterrupted testing time: \_\_\_\_\_ minutes, break time: \_\_\_\_\_ minutes

Other: \_\_\_\_\_

The professional diagnostician must identify all necessary accommodations.

# Section 3C

Provide any additional information that may assist with the approval of the request.

## Section 3C: Other Information and Supporting Documents

This section may be completed by the candidate or by his or her certifying professional or advocate. Provide any additional information you wish to be considered when this request for accommodations is reviewed.

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General Educational Development (GED) Testing Service will not discriminate against candidates for testing on the basis of any legally protected characteristic, including, but not limited to, race, color, religion, sex, sexual orientation, pregnancy, marital status, physical or mental disability, age, veteran status, and national origin.

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# **Learning & Other Cognitive Disabilities**

### Section 3: To be completed by Professional Diagnostician or Advocate

This section must be completed by the professional diagnostician. Alternatively, an advocate may complete this section using information from the professional diagnostician's report if the professional is unavailable or documentation is currently on file with a candidate's school district. An advocate is someone other than the professional diagnostician who helps the candidate request testing accommodations. The professional's report must indicate certification or licensure. Documentation and assessment tests must include a clear diagnosis and provide information on current functional limitations that might affect the candidate's ability to take the tests under standard conditions, so that the rationale for the requested accommodation can be properly evaluated. Documentation will be viewed as sufficiently current if it has been completed within the last 5 years. However, older documentation will be considered if that is all that the candidate can provide without undue burden or expense.

Please indicate your role:  Professional Diagnostician  Advocate

Name of Professional Making Diagnosis (please print): \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Date of Assessment: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

Highest Degree and Area of Specialization: \_\_\_\_\_

License Number: \_\_\_\_\_ Expiration: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ State/Province/Territory: \_\_\_\_\_  
MM DD YYYY

Name of Advocate (please print): \_\_\_\_\_

Relationship to Candidate (please print): \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Professional Making Diagnosis or Advocate's Signature: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

- Check the box for either the professional or advocate
- If the advocate is completing the form they should transfer as much of the professional diagnostician information from the documentation as possible

LD

# Section 3A

## Section 3A: Measurement of Academic Achievement (Standard Scores)

To be completed by the professional diagnostician or advocate.

Date(s) of Assessment(s):      /      /       
                                  MM      DD      YYYY

**Test Used (select one):**

WJ-R             WJ-III, Ach.     WIAT-I             WIAT-II

**Current Achievement (Include Standard Scores):**

**Broad Reading:** \_\_\_\_\_                      **Broad Math:** \_\_\_\_\_  
Word Identification: \_\_\_\_\_                      Calculation: \_\_\_\_\_  
Comprehension: \_\_\_\_\_                      Applied Problems: \_\_\_\_\_

**Broad Written Language:** \_\_\_\_\_                      **Broad Knowledge:** \_\_\_\_\_  
Dictation: \_\_\_\_\_                      Skills: \_\_\_\_\_  
Writing Sample: \_\_\_\_\_                      Other: \_\_\_\_\_

**Other Primary Tests Accepted (if Woodcock Johnson or Weschler not used):**

PIAT-R/NU     PIAT-R     K-TEA     K-TEA/NU     WRMT-R/NU     Key Math - R/NU

**Current Achievement (Include Standard Scores):**

Subtest Name: _____	Subtest Score: _____	Standard Score: _____
Subtest Name: _____	Subtest Score: _____	Standard Score: _____
Subtest Name: _____	Subtest Score: _____	Standard Score: _____
Subtest Name: _____	Subtest Score: _____	Standard Score: _____

Select only one  
Academic  
Achievement Test .

Only provide data in  
the corresponding  
box.

# LD

## Section 3A

**This information must be completed by the psychological diagnostician or advocate if the professional is different than the professional listed in section 3.**

This section must be completed by the professional diagnostician. Alternatively, an advocate may complete this section using information from the professional diagnostician's report if the professional is unavailable or documentation is currently on file with a candidate's school district. An advocate is someone other than the professional diagnostician who helps the candidate request testing accommodations. The professional's report must indicate certification or licensure. Documentation and assessment tests must include a clear diagnosis and provide information on current functional limitations that might affect the candidate's ability to take the tests under standard conditions, so that the rationale for the requested accommodation can be properly evaluated. Documentation will be viewed as sufficiently current if it has been completed within the last 5 years. Older documentation will also be considered, however, if that is all that the candidate can provide without undue burden or expense.

Check here if you are also the professional diagnostician listed in Section 3

**Please indicate your role:**  Psychological Diagnostician  Advocate

Name of Psychologist (please print): \_\_\_\_\_

Phone Number: ( ) - FAX Number: ( ) -

Highest Degree and Area of Specialization: \_\_\_\_\_

License Number: \_\_\_\_\_ Expiration:    /    /    State/Province/Territory: \_\_\_\_\_

Name of Advocate (please print): \_\_\_\_\_

Relationship to Candidate (please print): \_\_\_\_\_

Phone Number: ( ) -

**Psychologist Making Diagnosis or Advocate's Signature:** \_\_\_\_\_



Date:    /    /   

■ To be completed only if the professional diagnostician is different in Section 3.

# LD

## Section 3B

- Provide the date(s) of assessment(s)
- If you select a WISC-III or WAIS-III, provide the data for all of the requested areas

  **Request for Testing Accommodations**  
Learning and Other Cognitive Disabilities  
8051

To be completed by Chief Examiners  
Candidate's Last 4 SSN/SIN

**Section 3B: Measurement of Potential or Intelligence (Test Scores)**

To be completed by the professional diagnostician or advocate.

Date(s) of Assessment(s): \_\_\_ / \_\_\_ / \_\_\_

**Test Used:**  
 WISC-III     WAIS-III

Verbal IQ: \_\_\_\_\_ Performance IQ: \_\_\_\_\_ Full Scale IQ: \_\_\_\_\_

**Index Scores:**  
Working Memory (WMI): \_\_\_\_\_ Processing Speed: \_\_\_\_\_  
Perceptual Organization (POI): \_\_\_\_\_ Verbal Comprehension (VCI): \_\_\_\_\_

**Subtest Scaled (i.e., Standard) Scores (mean of 10 with range of 1-19):**

Information: _____	Similarities: _____	Object Assembly: _____
Digit Span: _____	Letter-Number Sequencing: _____	Digit Symbol: _____
Vocabulary: _____	Picture Completion: _____	Coding (WISC-III): _____
Arithmetic: _____	Picture Arrangement: _____	Matrix Reasoning (WISC-III): _____
Comprehension: _____	Block Design: _____	Symbol Search: _____

# LD

## Section 3B

**Test Used:**

SB-IV       SB-V

**Subtest**

**Standard Score**      **Estimated Age Score**

Verbal Reasoning: \_\_\_\_\_

Abstract/Visual Reasoning: \_\_\_\_\_

Quantitative Reasoning: \_\_\_\_\_

Short-Term Memory: \_\_\_\_\_

**Test Composite:** \_\_\_\_\_

**Test Used:**

WJ-III, Cog

**Subtest**

**Percentile Rank (Age)**      **Standard Score (Age)**

Verbal Comprehension: \_\_\_\_\_

Visual-Auditory Learning: \_\_\_\_\_

Numbers Reversed: \_\_\_\_\_

Visual Matching: \_\_\_\_\_

Sound Blending: \_\_\_\_\_

Spatial Relations: \_\_\_\_\_

Concept Formation: \_\_\_\_\_

GIA Score: \_\_\_\_\_

- If you select a SB-IV or SB-V, provide the data for all of the areas provided
- If you select WJ-III, Cog provide data (percentile rank and standard score) for each of the subtest

**LD**

## **Section 3C**

Identify a disability and provide DSM-IV Codes

### **Section 3C: Diagnosed Disability**

The professional diagnostician or advocate must select all appropriate diagnosed disabilities.

#### **Specific Learning Disabilities (check all that apply)**

- Reading Disability (identify: \_\_\_\_\_)
- Mathematics Disability (identify: \_\_\_\_\_)
- Written Language Disability (identify: \_\_\_\_\_)
- Other cognitive disabilities (list all that apply):

\_\_\_\_\_

\_\_\_\_\_

DSM-IV Code(s): \_\_\_\_\_

LD

## Section 3D

The professional diagnostician must identify all necessary accommodations.

### Section 3D: Requested Accommodations

Please identify those accommodations that support the diagnosed disability.

Extended Time (please specify):  1-1/2times  2times  Other: \_\_\_\_\_

Audiocassette (tone-indexed) (requires extended testing time, generally double time)

2times  Other: \_\_\_\_\_

*The use of this accommodation requires practice. Candidates should have an opportunity to practice using an Official GED Practice Test, Audiocassette Version prior to the scheduled testing date.*

Scribe

Calculator for Part II

Talking Calculator for Entire Mathematics Test

PrivateRoom

Supervised Breaks (specify in minutes):

Uninterrupted testing time: \_\_\_\_\_ minutes, break time: \_\_\_\_\_ minutes

Other: \_\_\_\_\_

**LD**

## **Section 3E**

Provide any additional information that may assist with the approval of the request.

### **Section 3E: Other Information and Supporting Documents**

This section may be completed by the candidate or by his or her certifying professional or advocate. Provide any additional information you wish to be considered when this request for accommodations is reviewed.

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# Testing Accommodations

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# Appeal

APP

# Testing Accommodations Appeal

 1977	<b>Testing Accommodations Appeal</b> Date Appeal Submitted: <input type="text"/> / <input type="text"/> / <input type="text"/>	To be completed by Chief Examiners Candidate's Last 4 SSN /SIN
<b>Section 1: To be completed by GED Candidate</b>		
Dear Candidate: You or the person who is helping you complete this form may initiate an appeal of a decision to deny any requested accommodation. Please complete this form with all of the requested information. The GED Examiner will complete Section 2. Once you complete this form, attach any additional documentation that may help with the decision process, and return this form to the GED Chief Examiner at the Official GED Testing Center where you started the accommodations process.		
Last Name: _____ First Name: _____ Social Security or Social Insurance Number: _____ Birth Date: <input type="text"/> / <input type="text"/> / <input type="text"/>		
Address: _____ City: _____ State/Province/Territory: _____ ZIP/Postal Code: _____		
<b>Please attach a copy of your original Request for Testing Accommodations form and any additional documentation in support of your appeal.</b>		
Please describe your situation and your reasons for appealing the decision regarding your testing accommodations request. Attach additional pages if your appeal requires additional documentation. _____ _____		
Candidates' Signature: _____		

The Candidate should complete Section 1 and provide attach all additional documentation. Describe the situation and sign Appeal Request.

APP

# Testing Accommodations Appeal

**Section 2: To be completed by GED Chief Examiner**

Chief Examiner: \_\_\_\_\_ State/Province: \_\_\_\_\_

Center ID: \_\_\_\_\_ Center Name: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ FAX Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Date Initial Testing Accommodation Request Submitted:  /  /  Date of Response:  /  /

**Disability Type:**

Specific Learning Disability  Attention-Deficit/Hyperactivity Disorder

Physical or Chronic Health Condition  Emotional or Mental Health Condition

Section should be completed by the Chief Examiner. Provide date of initial accommodation request and the disability type.

APP

# Testing Accommodations Appeal

Only needs to be completed if the original professional diagnostician(s) are different on the original request.

## Section 3: To be completed by Professional Diagnostician or Advocate

Please indicate your role:  Professional Diagnostician  Advocate

Name of Professional Making Diagnosis (please print): \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Date of Assessment:  /  /

Highest Degree and Area of Specialty: \_\_\_\_\_

Licensure or Certification: State / Province: \_\_\_\_\_ Number: \_\_\_\_\_

Expiration Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Name of Advocate (please print): \_\_\_\_\_



Employment of Advocate (please print): \_\_\_\_\_ Education Level of Advocate (please print): \_\_\_\_\_

**Professional/Advocate's Signature:** \_\_\_\_\_

APP

# Testing Accommodations Appeal

Should be completed by the Jurisdictional Administrator.

  **Testing Accommodations Appeal** To be completed by OTHER Examiners  
1977 Candidate's Last 4 SSN /SIN

**Section 4: To be completed by GED Administrator**

Approved for:

- Extended Time (please specify):  1-1/2 times  2 times  Other: \_\_\_\_\_
- Audiocassette (tone indexed) (will require extended testing time, generally double time)  
 2 times  Other: \_\_\_\_\_  
*The use of this accommodation requires practice. Candidates should have an opportunity to practice using an Official GED Practice Test, Audiocassette Version prior to the scheduled testing date.*
- Braille
- Scribe
- Calculator for Part II
- Talking Calculator for Entire Mathematics Test
- Private Room
- Supervised Breaks (specify in minutes):  
Uninterrupted testing time: \_\_\_\_\_ minutes, break time: \_\_\_\_\_ minutes
- Other: \_\_\_\_\_

Appeal forwarded to GEDTS for review (explain reasons below).

Not approved (explain reasons below).

\_\_\_\_\_  
*Signature of Administrator*                      *Telephone Number*                      *Date*

Reasons for forwarding appeal to GEDTS for review:  
\_\_\_\_\_  
\_\_\_\_\_

Reasons for not approved:  
\_\_\_\_\_

APP

# Testing Accommodations Appeal

Identify who is making the request for an Appeal

## Section 5

Requested by Administrator     Requested by Candidate