



Washington State Department of

Health

Mental Health Credentialing

P.O. Box 47877

Olympia, WA 98504-7877

360-236-4700

## Accommodation Request

If you have a disability and require accommodation in taking the examination, please complete and submit this form. The information requested below and any documentation regarding your disability and your need for accommodation in testing will be considered strictly confidential and will not be shared with any outside source without your express written permission. [Section 504 of the Rehabilitation Act (29 USC 12101)].

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

Address: \_\_\_\_\_

Phone (enter 10 digit #): \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Accommodations requested for the: \_\_\_\_\_ License Examination  
Date

Type of Disability: \_\_\_\_\_

Requesting the following accommodation(s) at the testing site: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

## Documentation of Disability Related Needs

If you have a learning disability, a psychological disability, or other hidden disability that requires an accommodation in testing, please have this section completed by an appropriate professional (learning specialist, doctor, psychologist, psychiatrist) to certify that your disabling condition requires the requested test accommodation.

If you have existing documentation of having the same or similar accommodation provided to you in another test situation, you may submit such documentation instead of having this portion of the form completed.

I have known \_\_\_\_\_ since \_\_\_\_\_  
Test Applicant Date

The applicant has the disability: \_\_\_\_\_

Diagnosed by the following tests or studies: \_\_\_\_\_

I recommend the following accommodation(s) be provided for this individual: \_\_\_\_\_

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

Address: \_\_\_\_\_

Title: \_\_\_\_\_ Phone: \_\_\_\_\_

Date: \_\_\_\_\_ License Number: \_\_\_\_\_