



**PLEASE COMPLETE THIS FORM IF YOU REQUEST  
A TEST ACCOMMODATION.  
THE INFORMATION WILL BE KEPT CONFIDENTIAL.**

**REQUEST FOR ACCOMMODATION IN TESTING**

The City University of New York is committed to providing a fair and accessible test environment for all applicants. Accommodations for test components of this examination are available for applicants with certified disabilities. Please review the description of all the exam components in the Notice of Examination to determine if you may require an accommodation. If you have a disability **AND** require an accommodation in testing, you must complete both sides of this form and submit to:

**CPS HR Consulting  
ATTN: CUNY Examinations  
2450 Del Paso Road, Suite 160,  
Sacramento, CA 95834**

by the close of the filing period for the test for which you require an accommodation. In requesting an accommodation in testing, you are required to provide a description of the type of accommodation for which you are applying and proof of your need for accommodation.

If you are requesting more test administration time because of a cognitive disability, please note that an additional hour is built into the administration time of any test we offer (e.g., you would have four hours to complete a three hour test).

Name \_\_\_\_\_

Social Security Number (last **5 digits** only) \_\_\_\_\_

Examination Title and Number \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

(OVER)

The information requested on this form, including any documentation regarding your disability and need for accommodation in testing, will be considered confidential. Please furnish all information as requested.

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

**Need for Accommodation (to be completed by the applicant)**

Please indicate below why you need an accommodation and what accommodations you believe are necessary in order to provide an accessible test format. Be as specific as possible when requesting an accommodation. For example, "I am legally blind and, therefore, need the assistance of a reader."

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Your request for accommodation in testing must be certified by an appropriate professional (licensed physician, approved agency, etc.), who must complete and sign the certification below. Additional materials documenting the need for accommodation may be attached. It is the applicant's responsibility to obtain that certification.

**Certification of Need for Accommodation (to be completed by an appropriate professional)**

I attest that this applicant has the disability described above. The applicant has discussed with me the nature of the test to be administered, and it is my opinion that the accommodation described above is appropriate for this applicant's disability.

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Telephone #

\_\_\_\_\_  
License #

\_\_\_\_\_  
Title (please print)

\_\_\_\_\_  
Date Applicant Was Last Examined

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date