



Documentation of Disability-Related Needs

2025 - TE-0226.1

Please have this section completed by an appropriate professional (education professional, physician, psychologist or psychiatrist) to ensure that the NCCT and/or testing vendor is able to provide the required accommodations.

PROFESSIONAL DOCUMENTATION

I have known _____ since ____ / ____ / ____ in my capacity as a
Examination Candidate Date

Professional Title/Credential(s)

Please provide professionally recognized diagnosis for the particular category of the disability.
Provide the specific diagnostic criteria. Provide candidate's limitation due to disability:

It is my professional opinion that, because of the aforementioned disability, this candidate should be considered for the following test accommodation(s):

- Extended time (time and a half)
- Distraction reduced environment
- Audible reader
- Other special accommodations covered by the Americans with Disabilities Act (ADA)

Signed: _____ Title: _____

Printed Name: _____

Address: _____

Telephone Number: _____ E-mail Address: _____

Date: _____ License # (if applicable): _____

Email this form with your examination application to:
accommodations@ncctinc.com