

Special Accommodation Documentation

This section is to be filled out by an appropriate professional (e.g., physician, psychologist, rehabilitation counsellor, special educator, or other professional).		
Last Name	First Name	Title
Tel: ()		<p>Any information submitted regarding the disability of the candidate is confidential and will not be shared with any party outside of APGNS.</p>
E-Mail Address:		
How many years have you know the candidate in the capacity of your current profession?		
Describe the nature of the candidate's disability:		
<p>The candidate should be accommodated by the following (select all that apply):</p> <input type="checkbox"/> Extended testing time (specify time needed) <input type="checkbox"/> Extra break(s) <input type="checkbox"/> Larger font exam <input type="checkbox"/> Reduced-distraction testing room <input type="checkbox"/> Other (please specify) _____ _____ _____		
Comments:		
Date: _____ Signature: _____		