**Disability Accommodation Request**

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)]. Please call 360-236-4700 if you have questions about the types of accommodations available.

Name ____________________________________________
Address ____________________________________________
Phone ____________________________ Social Security Number ____________________________

Accommodations requested for the ________________________________ Midwifery examination.

I have the disability ____________________________________________ and request the following accommodation(s) at the testing site ________________________________

Name (please print) ____________________________________________

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 licensed health care professional (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, for example in your midwifery education program, you may submit such documentation instead of having this portion of the form completed.

I have known ___________________ since ______________ in my capacity as a ______________________

Test applicant mm/yyyy Professional title ________________________

The applicant has the disability ____________________________________________

diagnosed by the following tests or studies ________________________________

I recommend the following accommodation(s) be provided for this individual ________________________________

Name (please print) ____________________________________________
Address ____________________________________________

Telephone ____________________________ License Number ____________________________

Signed ____________________________ Date _______________________

If accommodations for testing were made for the candidate during progression through the Midwifery education program, provide a letter from the director indicating what modifications were made.