

## INSTITUTIONAL VERIFICATION OF DOCUMENTATION

(Must be printed on official institution letterhead)

## For Oregon licensure candidates:

Mail to:

Evaluation Systems Pearson P.O. Box 340880 Sacramento, CA 95834-0880

Phone: (916) 928-4017

## For all other candidates:

Mail to:

Evaluation Systems Pearson P.O. Box 660 Amherst, MA 01004

Phone: (800) 778-5315

This form may be completed by an institutional representative to fulfill documentation requirements for examinees requesting the specific alternative testing arrangements indicated in section 8 of this form. This form will not be accepted as supporting documentation for any alternative testing arrangement not listed in section 8 of this form.

This form must be completed in its entirety, signed by an authorized professional from the Office of Disability Services at the examinee's college or university, and **printed on official institution letterhead**. Forms that do not meet these requirements will not be processed.

Examinee Information (as indicated by the examinee at the time of registration and as appears on the Alternative Testing Arrangements Request Form completed by the examinee):

1.	Examinee	Examinee Name																					
	Last														First							_	Middle
2.	Examinee	Cust	ome	er N	umk	oer (	four ]	nd in	exa	ımin	ee's	acco	ount	at t	he p	rogr	am	web	osite	<del>)</del> )			Initial
	thorized In		utio	nal	Re	pres	sen	tati	ve I	nfo	rma		n . Ti	tle									
											_		_										
5.	Institution																						
6.	Telephone Number										7. Email Address												
	Area Code	_						•	•														

8.	Alternative Testing Arrangements													
	Indicate which of the following accommodations are supported by the documentation on file at your institution and provided by your institution for the above-named examinee. If the examinee is requesting an alternative testing arrangement not listed below, documentation must be submitted directly to Evaluation Systems.													
	□ 50	% Extra time (time and one half)		☐ Oral interpreter (for	r oral directions)									
	□ Sig	gn language interpreter (for oral directions)												
Dod		tation e provide the following information contained nee named in section 1 of this form.	in the i	most recent document	ation on file for the									
9.		and credentials of diagnosing profession be a different individual than is named in sec		of this form)										
10.	Diagn	osed disability or disabilities:	11.	Date of the evaluation	on:									
12.	Certifi	cation												
	By init	ialing each statement below, I certify that:												
	*	The documentation on file for this examine described in "Required Documentation" on			Initials									
	*	The documentation on file for this examine												
	*	the "Documentation Currency Policy" on the			Initials									
	**	The applicant is requesting only accommo section 8 of this form.	ualions	s triat are listed in	 Initials									
13	instituthe coalterrile won the included Document of the control of	ify that I am the person whose name apperution letterhead. I have reviewed the "Requurrent program website and certify that the chative testing arrangements referenced on the ith the institution named on this form. I agree its form for Evaluation Systems upon request de routine audits. Evaluation Systems reserve mentation option for an institution found to be ult of such an audit. I understand that the expitting a completed Alternative Testing Arrangement	lesting locume is form e to pro as part es the le in no camine	Alternative Testing Arentation supporting the meets the criteria desoduce a copy of the doct of program monitoring right to suspend the Incompliance with assoe authorizes the release	rangements" section of examinee's request for scribed therein and is on cumentation referenced and review, which may stitutional Verification of ociated requirements as see of this information by									