PRAXIS/SCHOOL LEADERSHIP SERIES TESTING ACCOMMODATIONS REQUEST FORM
Part III — Certification of Eligibility: Accommodations History

Applicant's Name: _____
(Please Print) First Name M.I. Last Name

The Certification of Eligibility (COE): Accommodations History form serves two distinct purposes:

- to provide verification of an individual's use of accommodations in either college or in the workplace
- as a shortcut for approval of certain specific accommodations for most disabilities

A completed COE: Accommodations History will only be considered in place of disability documentation from qualified applicants with

1. Learning Disability (LD), Attention Deficit Hyperactivity Disorder (ADHD), Traumatic Brain Injury (TBI), Autism Spectrum Disorder (ASD), psychiatric disabilities and/or physical disabilities, who are requesting 50% extended time or less and/or additional breaks only; OR
2. Blindness/legal blindness and/or hearing loss who are requesting those accommodations listed on page 7 for these conditions.

For any other accommodations (double time, scribe, reader, etc.) applicants must submit disability documentation or verification of approval of the same accommodations from another standardized testing agency directly to ETS for review.

This form must be completed and signed by an authorized professional representing one of the following:

- Office of Accessibility/Disability Services at test taker's college or university
- Human Resources office at test taker's place of employment
- Department of Vocational Rehabilitation (DVR) office in test taker's state of residence

Certification of Eligibility: Accommodations History forms completed and signed by members of the applicant's family, or by the individual who diagnosed or is treating the disability, will not be considered.

After reading this page, please complete pages 16 to 19.

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Part III — Certification of Eligibility: Accommodations History *(continued)*

Applicant's Name: _____
(Please Print) First Name M.I. Last Name

DIRECTIONS FOR COMPLETING THE CERTIFICATION OF ELIGIBILITY: ACCOMMODATIONS HISTORY

The COE can be used in lieu of documentation or as verification of the accommodations used in a postsecondary setting. The authorized professional should initial each of the documentation criteria listed below. Please clearly write your initials for each item.

Does the candidate's documentation…

	Yes	No	N/A	
1.	____	____	____	Meet the recency guidelines set forth at ***www.ets.org/disabilities***?
2.	____	____	____	Include complete educational, developmental, and medical history relevant to the disability for which accommodations are being requested?
3.	____	____	____	Describe the functional limitations resulting from the diagnosed disability?
4.	____	____	____	List the test instruments used in the evaluation report and relevant subtest scores used to document the stated disability? (All test instruments should have adult norms.)
5.	____	____	____	Describe the specific accommodation(s) requested and adequately support each requested accommodation?
6.	____	____	____	Present itself on official letterhead, typed, signed, and dated by an evaluator qualified to make the diagnosis (include information about license, certification, and area of specialization)?

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Applicant's Name: _____
(Please Print) First Name M.I. Last Name

Provide the following information regarding the disability documentation on file:

A. Name and credentials of the professional who completed the most recent evaluation.
(e.g., Susan Smith, MD, Psychiatrist)

_____ _____ _____
Name Degree Area of Expertise

B. Date of professionals most recent evaluation: _____/_____
Month Year

C. Applicant's diagnosed disability or disabilities, as stated in the documentation, for which accommodations have been granted:

D. Please indicate the accommodations the applicant has received at your institution.

Extended testing time (**NOTE:** All tests are timed; if you are requesting more than 50 percent extended test time, you must submit disability documentation or verification of approval of the same accommodations from another standardized testing agency directly to ETS for review.)
Please check the appropriate box:

☐ 25% ☐ 50% ☐ 100% ☐ Other _____

Please list all other approved testing accommodations: If the student used a "reduced distraction testing environment," please describe that environment.

1. _____
2. _____
3. _____
4. _____
5. _____

E. During what period of time has the applicant used the above accommodations?

From _____/_____ To _____/_____
Month Year Month Year

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F. Has the applicant used these accommodations for at least one semester or four months?

_____yes _____no

G. Where has the applicant used the accommodations?
- ☐ College/University
- ☐ Place of Employment
- ☐ Other (indicate): _____

I certify that the accommodations indicated in Part III – *Certification of Eligibility: Accommodations History* form are those that were documented as necessary and approved for the applicant.

I certify that I have reviewed the Educational Testing Service (ETS) Disability Documentation Guidelines, and that the applicant's documentation supporting the disability or disabilities and the need for specific accommodations is in line with those guidelines and on file in this office. For quality assurance, Part III – *Certification of Eligibility: Accommodations History* form may be subject to an audit resulting in a review of the actual disability documentation on file.

In the event that ETS requests a copy of any of the documentation cited above, I agree to send ETS, for its consideration, the complete file of documentation pertinent to establishing the need for these accommodations. I understand that the applicant authorizes the release of this information pursuant to the applicant's verification statement.

I also understand that if ETS determines at any time that the applicant's documentation is not in line with ETS's Disability Documentation Guidelines, ETS will withhold or cancel the applicant's score(s).

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Part III — Certification of Eligibility: Accommodations History *(continued)*

Applicant's Name: _____
(Please Print) First Name M.I. Last Name

Authorized Professional's Verification Statement

To be signed by an authorized person in the Office of Accessibility/Disability Services, a Human Resources counselor at place of employment or a Vocational Rehabilitation counselor. **NOTE: The evaluator who diagnosed or is treating the individual cannot complete this form.**

_____ _____
Signature of Authorized Professional Today's Date

_____
Print Name

_____
Title

_____
Name of Institution/Agency/Place of Employment

_____ _____
Telephone Fax #

_____
Email Address

Attach Business Card Here