CAP Request for Accommodations Form

To be completed by the person seeking accommodations.

❑ IAAP Member/ID Number_____ ❑ Nonmember

Name (Last/First/M.I.

Current street address | City | State/Prov | ZIP/PC

Email address | Daytime phone #

Description of disabilities

Accommodation requests

CAP Exam Administration ☐ Fall ☐ Spring Year_____

Have you requested your appointment date and time? ☐ Yes ☐ No

Under penalty of perjury, I declare that the representations that I have made in this Request for Accommodations and any supporting documentation are true to the best of my knowledge. I understand that false information may result in the denial or revocation of accommodations and/or certification. I hereby certify that I personally completed this form and that I may be asked to verify this information at any time. I understand that the CAP program reserves the right to make additional inquiries regarding my disability and previous accommodations before rendering a decision.

If clarification or further information is required, I authorize the CAP program to communicate with the professional(s) who diagnosed the disability, the professional(s) who provided information related to my Request for Accommodations, and any entities that have granted accommodations to me in the past. I understand that the CAP program may request additional documentation from the persons and/or entities referenced above and/or me. I also authorize the CAP program to release this information to a professional chosen by the CAP program for the purpose of conducting an independent evaluation of the requested accommodations. I acknowledge that these processes may require extra time for the accommodations to be granted.

Your Signature | Date

This form is valid for one year from the date of the candidate's signature.

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