

**North Carolina State Board of Certified Public Accountant Examiners**

1101 Oberlin Road Suite 104 • PO Box 12827 • Raleigh NC 27605

Phone 919-733-4224 • Fax 919-733-4209 • Web www.nccpaboard.gov

**DOCUMENTATION OF ACCOMMODATION HISTORY FOR CANDIDATES WITH DISABILITIES**

This form must be completed by a professional responsible for student disability services at the institution which the candidate attended during that education. This form documents the candidate's history of testing accommodation during higher education. Return this form with the examination application.

**I. EXAMINATION CANDIDATE INFORMATION**

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Examination Repeater: \_\_\_\_ Yes \_\_\_\_ No

**II. STUDENT DISABILITY SERVICES PROFESSIONAL INFORMATION**

Professional's Name: \_\_\_\_\_

Title: \_\_\_\_\_

Institution: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_

**III. CANDIDATE'S DISABILITY STATUS (Check all that apply)**

\_\_\_\_\_ orthopedic/physical disability \_\_\_\_\_ hearing impaired  
\_\_\_\_\_ specific learning/learning-related disability \_\_\_\_\_ deaf  
\_\_\_\_\_ psychological/psychiatric/behavioral disability \_\_\_\_\_ visually impaired  
\_\_\_\_\_ blind  
\_\_\_\_\_ other health disability/impairment (specify) \_\_\_\_\_

**IV. ACCOMMODATIONS PROVIDED TO CANDIDATE DURING HIGHER EDUCATION**

1. The following testing accommodations were provided for the candidate while a student at this institution.

**Architecturally Accessible Site**

\_\_\_\_\_ Wheelchair accessibility \_\_\_\_\_ Elevator

**Formats**

\_\_\_\_\_ Large type (specify pt. ) \_\_\_\_\_  
\_\_\_\_\_ Recording of answers in test booklet rather than on scannable answer sheet  
\_\_\_\_\_ Other (specify) \_\_\_\_\_

**Assistance**

Reader                       Sign language interpreter  
 Writer/Recorder               Separate room and proctor  
 Other (specify) \_\_\_\_\_  
 \_\_\_\_\_

**Extended Time**

For classroom tests, specify amount of extra time: \_\_\_\_\_  
 For standardized tests, specify amount of extra time: \_\_\_\_\_

**Other accommodations (specify):** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

2. Please provide the dates or time period during which these accommodations were provided to student:

\_\_\_\_\_

3. Reason these accommodations were provided:

\_\_\_\_\_  
\_\_\_\_\_

4. Testing accommodations were arranged for the student and monitored by this office of student disability services.

Yes     No

5. Testing accommodations were arranged for the student and monitored by this institution's faculty.

Yes     No

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I certify that the information provided by me on this form is true and correct to the best of my knowledge.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**NOTE: THIS FORM MUST BE ENCLOSED WITH THE CANDIDATE'S COMPLETED EXAMINATION APPLICATION.**