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

PHYSICIAN'S VERIFICATION OF DISABILITY AND ACCOMMODATION

This form must be completed by a licensed or qualified professional whose credentials are appropriate to diagnose and evaluate the candidate's disability and make recommendations as to appropriate testing accommodations for individuals with the disability. The professional must have treated, diagnosed, or had some other professional relationship with the candidate *within the last five years.* Attach additional sheets as needed. If the candidate has received accommodations during his or her education, the candidate must submit the completed **Documentation of Accommodation History** form with the completed examination application.

I. EXAMINATION CANDIDATE INFORMATION

Name: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime Telephone Number: _____

Examination Repeater: ____ Yes ____ No If repeater, date of last examination: _____

II. LICENSED/QUALIFIED PROFESSIONAL INFORMATION

Professional's Name: _____

Title: _____

Institution: _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime Telephone Number: (_____) _____

III. DIAGNOSIS AND TREATMENT INFORMATION

A. Diagnosis: _____
(If a specific learning disability, learning-related, or psychological disability, please provide identification of the DSM-III-R or DSM-IV diagnosis.)

B. Describe this diagnosis: _____

C. Date of last/most recent date of treatment or consultation with the candidate: _____

D. Explain the aspect(s) of the disability which requires testing accommodation and the effect of the disability
on the candidate's ability to perform under normal testing conditions: _____

E. If the candidate has a specific learning disability or psychological disability, identify the *specific assessments* (e.g., standardized psychological/educational tests) used to identify and confirm the diagnosed disability. Please enclose copies of these test results/evaluations/educational or psychological reports with this form. _____

_____

_____

_____

F. Based on your knowledge of this candidate's disability, which of the following accommodations are recommended? (check all that apply)

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

_____ Indicate amount of extra time requested: _____

Please provide a rationale for the specific amount of extended time recommended _____

_____

_____

_____

Other Accommodation(s) (specify): _____

_____

G. How is/are the recommended accommodation(s) related to the candidate's disability in regard to multiple choice and/or essay exams?_____

_____

_____

_____

H. Please describe your qualifications/credentials and your professional relationship with this candidate which qualifies you to provide these recommendations for testing: _____

_____

_____

_____

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

_____ _____ _____

Signature License/Certification Number Date