CRC SPECIAL ACCOMMODATION FORM

Candidates with disabilities covered by the Americans with Disabilities Act (or the Canadian equivalent) should complete this form so their request for accommodations can be processed efficiently. The information provided and all related documentation regarding the disability and the need for the accommodation will be treated with strict confidentiality.

***Please note: incomplete or late requests will not be honored.

About You

Please Print Clearly

Member Number

Mr.      Ms.      Mrs.      Dr.

First Name M.I. Last Name

Job Title

Preferred Mailing Address

Phone      Fax

Email

I would like the following testing accommodation(s):

- Wheelchair access
- Special seating
- Screen magnifier
- Reader
- Recorder
- Separate testing area
- Extended testing time
  - Please specify in the space provided below.

- Other
  - Please specify in the space provided below.

By submitting this CRC Special Accommodation form, I accept the conditions set forth by RMA for the CRC examination. I understand that I am subject to all policies concerning cancellations, refunds, transfers, and administration of the test, reporting of the test scores and the complete certification process and policies including the CRC recertification process. I certify that the information contained in my application is true, complete and, correct to the best of my knowledge and is made in good faith.

Signature

Date

W2005
For Disability-related needs:

This form must be completed by a licensed health care provider or an educational or testing professional to ensure that RMA and Pearson VUE are able to provide the required exam accommodations.

To be completed by licensed health care provider:

The nature of the disability, identification of the tests(s) used to confirm diagnosis, a description of past accommodations made for the disability, and the specific testing accommodations requested must be included.

I have known __________________ Since __________________

(Name of applicant)

In my capacity as a(n) __________________

(Professional title)

The applicant discussed with me the nature of the test to be administered. It is my opinion that because of this applicant’s disability described below, he or she should be accommodated by providing the special arrangements listed on the first page of this form.

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________________________________________

Signature:_______________________________

Title:_______________________________ Date:_______________________________

License#: (if applicable)_______________________________

Please fax this completed form to 215-446-4100 within five business days of submitting your CRC Application.

Questions? Call 800-677-7621 or email us at rmacertification@rmahq.org.