6027

Request for Testing Accommodations
Emotional/Mental Health

To be completed by Chief Examiners

Candidate's Last 4 SSN/SIN

Section 1: To be completed by GED Candidate

Fill in this section completely and sign the release of information statement. Make certain all sections are completed by the appropriate professional before you return the form to the Chief Examiner at your local testing center. The Chief Examiner will review the form and let you know if additional information is required.

Last Name: _____ First Name: _____

Social Security or Social Insurance Number: ___-___-___ Birth Date: ___/___/_____ Age: _____
(MM / DD / YYYY)

Address: _____

City: _____ State/Province/Territory: _____ ZIP/Postal Code: _____

Phone Number: (_____) _____-_____

Release of information: If you are under 18 years of age, your parent or guardian's signature is also required.

I grant permission to school officials and my healthcare provider(s) to release my education-related records and/or my medical or psychological records to the GED Testing Service and its designees in connection with my request for testing accommodations.

_____ _____ _____

Candidate's Signature *Parent or Guardian's Signature (if appropriate)* *Date*

Section 2: To be completed by GED Chief Examiner

Please review the form to be certain all sections have been completed. Record the last four digits of the candidate's SSN/SIN in the top right corner of each page of this form. Missing information may delay the review of the candidate's request. Sign and date the form before sending it to your GED Administrator.

Chief Examiner Name: _____ 10-Digit Center ID #: _____

Center Name: _____

Phone Number: (_____) _____-_____ FAX Number: (_____) _____-_____

E-mail: _____

I have reviewed this application and confirm that it is complete.

_____ _____

GED Chief Examiner's Signature *Date*

Section 3: To be completed by Professional Diagnostician or Advocate

This section must be completed by the professional diagnostician. Alternatively, an advocate may complete this section using information from the professional diagnostician's report if the professional is unavailable or documentation is currently on file with a candidate's school district. An advocate is someone other than the professional diagnostician who helps the candidate request testing accommodations. The professional's report must indicate certification or licensure. Documentation and assessment tests must include a clear diagnosis and provide information on current functional limitations that might affect the candidate's ability to take the tests under standard conditions, so that the rationale for the requested accommodation can be properly evaulated. *Documentation will be viewed as sufficiently current if it has been completed within the last 6 months.* However, older documentation will be considered if that is all that the candidate can provide without undue burden or expense.

Please indicate your role: ☐ Professional Diagnostician ☐ Advocate

Name of Professional Making Diagnosis (please print): _____

Phone Number: (_____) _____-_____ Date of Assessment: ___/___/_____
(MM / DD / YYYY)

Licensure or Certification: Expiration Date: ___/___/_____

State/Province/Territory: _____ Number: _____ Specialty: _____

Name of Advocate (please print): _____

Relationship to Candidate (please print): _____

Phone Number: (_____) _____-_____

Professional Making Diagnosis or Advocate's Signature: _____

Date: ___/___/_____
(MM / DD / YYYY)

6027

Request for Testing Accommodations
Emotional/Mental Health

To be completed by Chief Examiners

Candidate's Last 4 SSN/SIN

Section 3A: Emotional/Mental Health Impairment

To be completed by the professional diagnostician or person helping you complete this form.

To request accommodations for an Emotional/Mental Health disability, the current level of impairment and resulting functional limitations must be clearly documented, as well as any history that can be provided. Documentation should also state a specific recommendation(s) for accommodations and the accompanying rationale.

Documentation must include a letter on official letterhead, signed by a certifying professional who specializes in the diagnosis of the disability, and providing supporting documentation of this disability.

☐ Supporting documentation on professional diagnostician's letterhead attached. (Required.)

DSM-IV Code: _____ **Diagnosis:** _____

Condition:

Functional Limitations: _____

Recommended accommodation(s): _____

Rationale for accommodation(s): _____

Section 3B: Requested Accommodations

Please identify those accommodations that support the diagnosed disability.

☐ Extended Time (please specify): ☐ 1-1/2 times ☐ 2 times ☐ Other: _____

☐ Audiocassette (tone-indexed) (requires extended testing time, generally double time)

☐ 2 times ☐ Other: _____

The use of this accommodation requires practice. Candidates should have an opportunity to practice using an Official GED Practice Test, Audiocassette Version prior to scheduled testing date.

☐ Braille

☐ Scribe

☐ Calculator for Part II

☐ Talking Calculator for Entire Mathematics Test

☐ Private Room

☐ Supervised Breaks (specify in minutes):

Uninterrupted testing time: _____ minutes, break time: _____ minutes

☐ Other: _____

Section 3C: Other Information and Supporting Documents

This section may be completed by the candidate or by his or her certifying professional or advocate. Provide any additional information you wish to be considered when this request for accommodations is reviewed.

_____

_____

General Educational Development (GED) Testing Service will not discriminate against candidates for testing on the basis of any legally protected characteristic, including, but not limited to, race, color, religion, sex, sexual orientation, pregnancy, marital status, physical or mental disability, age, veteran status, and national origin.

6027

Request for Testing Accommodations
Emotional/Mental Health

To be completed by Chief Examiners

Candidate's Last 4 SSN/SIN

Section 4: To be completed by GED Administrator

This section should be completed by the GED Administrator after reviewing the request for accommodations to document the outcome of the review.

☐ Approved For:

- ☐ Extended Time (please specify): ☐ 1-1/2 times ☐ 2 times ☐ Other: _____
- ☐ Audiocassette (tone-indexed) (requires extended testing time, generally double time)
  - ☐ 2 times ☐ Other: _____
  - *The use of this accommodation requires practice. Candidates should have an opportunity to practice using an Official GED Practice Test-Audiocassette Version prior to scheduled testing date.*
- ☐ Braille
- ☐ Scribe
- ☐ Calculator for Part II
- ☐ Talking Calculator for Entire Mathematics Test
- ☐ Private Room
- ☐ Supervised Breaks (specify in minutes):
  - Uninterrupted testing time: _____ minutes, break time: _____ minutes
- ☐ Other: _____

☐ Returned for more information. Date Returned: ____ / ____ / _____ (MM / DD / YYYY)

Reasons for returning request:

_____

_____

_____

☐ Request forwarded to GEDTS for review (explain reasons below.) Date Forwarded: ____ / ____ / _____ (MM / DD / YYYY)

Reasons for forwarding request to GEDTS for review:

_____

_____

_____

_____ _____ _____

GED Administrator's Signature *Telephone Number* *Date*