The Carpenters International Certification Council (CICC) complies with the Americans with Disabilities Act (ADA) of 1990 or other applicable disability discrimination laws. To ensure equal opportunities for all candidates, CICC will make reasonable testing accommodations for candidates when appropriate and consistent with such legal requirements. The CICC will consider requests for special testing accommodations related to the **written** exams from candidates who require such accommodations under applicable disability discrimination law ("accommodation").

A physician or other qualified medical care professional who has made an individualized assessment related to the candidate's request for an accommodation must provide the required information concerning the candidate's requested accommodation. A qualified medical care professional is a licensed or otherwise properly-credentialed individual who possesses medical expertise for evaluating any requested accommodation. The information and any documentation that the candidate provides regarding the need for accommodation(s) will be treated as confidential.

The CICC requires that each candidate requesting a special testing accommodation complete and submit this form by mail, fax, or email **at least 45 days prior** to testing. The Testing Accommodation Coordinator will send confirmation to the candidate that the request was received within five (5) business days of receipt. The confirmation will include the latest date when the candidate will receive notification of a decision. The Testing Accommodation Coordinator will respond with a final decision via email not more than **30 days** after receipt of the request. For reasons of confidentiality, information regarding the granting or denial of testing accommodations will not be released by telephone. All approved testing accommodation requests will be communicated to the Single Point of Contact (SPOC) at the test center and are valid for only one (1) year, and only for the written test date and/or practical test date indicated on page two (2) of this request form.

Candidates reapplying for a testing accommodation must resubmit a copy of the original accommodation request form with the "Resubmit Application" section on page seven (7) completed and a copy of their original testing accommodation approval letter attached. As long as the retest date on page seven (7) is within one (1) year of the original approval date that appears on the test accommodation approval letter, candidates will be approved under the same conditions. Requests must be made at least 45 days prior to testing.

Candidates seeking a different testing accommodation than what was originally requested or seeking an accommodation beyond the one (1) year deadline must submit a new form in its entirety (pages 1-5), along with the required signatures, updated dates, and supporting documentation from a qualified medical provider.

Test Center Information				
INSTRUCTIONS: To be completed by the UBC Affiliated Test Center.				
Single Point of Contact (SPOC) Name				
SPOC Email				
SPOC Phone Number				
Test Center Name				
Address				
City, State/Province, Zip/Postal Code, Country				
Candidate Name		UBC ID	U-	
Written Test Date				
SPOC Signature			Date	
Candidate Information				
INSTRUCTIONS: To be completed by the candidate**.**				
UBC ID Number	U-			
Candidate Name (First Middle Last)				
Home Address				
City, State/Province, Zip/Postal Code, Country				
Home Phone Number				
Cell Phone Number				
Email Address				

Qualified Medical Care Professional Information	
INSTRUCTIONS: To be completed by the physician or other qualified medical care professional who has made an individualized assessment of the candidate's request for an accommodation. A qualified medical care professional is a licensed or otherwise properly-credentialed individual who possesses medical expertise for evaluating any requested accommodation.	
Qualified Medical Care Professional Name	
Address	
City, State/Province, Zip/Postal Code, Country	
Phone Number	
Email Address	
Professional Title:	
License Number, and State Issuing License	
Professional Credential, and Organization Issuing Credential:	

Candidate/Patient Assessment	
INSTRUCTIONS: To be completed by the physician or other qualified medical care professional who has made an individualized assessment of the candidate's request for an accommodation. Please provide the required information concerning the candidate/patient.	
PLEASE NOTE: Nothing in this form will require you to disclose any patient diagnosis or any details regarding any medical conditions of the patient.	
Patient's Name	
Date medical condition or need for treatment began	
Probable duration of condition or treatment	

Requirements for Taking the Written Examination		
INSTRUCTIONS: To be completed by the physician or other qualified medical care professional who has made an individualized assessment of the candidate's request for an accommodation. The certification examination process requires the candidate to perform the following functions. Please check which ones the patient can and cannot perform.		
Yes	**No**	**Written Test Requirements**
		Follow oral and written directions
		Use a pencil to complete a bubble-style Scantron answer sheet
		Remain seated for up to four hours. *Note: Candidates may take breaks at any time during the three (3) hour exam; however, the exam timer will continue to run during breaks.*
		See written documents at a minimum of 12 point font size with or without corrective instruments limited to corrective eyeglasses and contact lenses.

NOTE: Certain medical or therapeutic equipment and supplies (e.g., eye drops, inhalers/diffusers, diabetic testing equipment) are not allowed in the testing room unless requested as an accommodation.

Requested Accommodation
INSTRUCTIONS: To be completed by the physician or other qualified medical care professional who has made an individualized assessment of the candidate's request for an accommodation. Please list all requested accommodations. All accommodations are considered on a case-by-case basis.
Please describe:

Signature of Qualified Medical Care Professional			
INSTRUCTIONS: By signing below, I verify that the information provided on this form and in the attached accommodations plan and documentation (if any) is complete and accurate to the best of my knowledge.			
Qualified Medical Care Professional Signature		Date	

Signature of Candidate			
INSTRUCTIONS: By signing below, I attest that the information I have provided on this application is accurate, true, and correct to the best of my knowledge. I agree to and authorize the release of this information requested to the CICC for use in determining eligibility for the requested testing accommodation. I understand that the CICC reserves the right to verify any and all information in my application. Therefore, I understand and agree that my failure to provide accurate, true, and correct information shall constitute grounds for disciplinary action.			
Candidate Signature		Date	

Mail, fax, or email completed form and any attachments to:	
Mail	ATTN: Test Accommodation Coordinator Carpenters International Certification Council 2450 Del Paso Road, Suite 220 Sacramento, CA 95834
Fax	(916) 561-8469
Email	CICCAccommodationRequest@cpshr.us

Complete this section only if you were previously approved for a testing accommodation and wish to resubmit pages 1-5 for retesting on another date. The retest date must be within one (1) year of the original approval date.

Resubmit Special Testing Accommodation Request Form

I am requesting to retest under the same conditions previously approved on my original request for special testing accommodations that appears on pages 1-5 above.

Resubmit Application			
INSTRUCTIONS: To be completed by the candidate**.**			
Test Center Name			
Address			
City, State/Province, Zip/Postal Code, Country			
Test Center Phone Number			
Written Test Retest Date		Written Test Retest Date must be within one year from the date of the original testing accommodation approval letter.	
Candidate Name		UBC ID	U-
Home Phone Number			
Cell Phone Number			
Email Address			
I have attached a copy of my original testing accommodation approval letter.			
Candidate Signature		Date	