



KENTUCKY COUNCIL ON  
POSTSECONDARY EDUCATION



## LAW AND ORDER:

# GED Testing Accommodation Process



## Program Director's Institute

### August 20 – 22, 2008



# ACCOMMODATIONS

- Do Not Provide:

Knowledge, Skill, Ability

- Do Provide A Level Playing to Demonstrate:

Knowledge, Skill, Ability

- Do not Affect Validity of Test

# Overview

- Laws Related to Disabilities
- Accommodation Process
- Accommodations Forms
- Advocacy
- Case Studies



# Disabilities and the Law

- **Rehab Act Section 504, 1973**

*prohibits discrimination if the program or agency receives federal funds*

- **ADA, 1990**

*prohibits discrimination in employment, or public services on the basis of a disability*

- **IDEA, 1997**

*guarantees special education services for children with disabilities*



# Roles and Responsibilities

- GED Candidate
- GED Examiner
- GED State Administrator
- GED Testing Service



# Testing Accommodation Forms

- Checklist used for candidates and examiners
- Emotional/Mental Health
- Physical/Chronic Health
- Attention-Deficit/Hyperactivity Disorder
- Learning and Other Cognitive Disabilities



# Request for Testing Accommodations Forms

  **Request for Testing Accommodations**  
Physical/Chronic Health Disability

To be completed by Chief Examiners

\_\_\_\_\_

Candidate's Last 4 SSN/SIN

**Section 1: To be completed by GED Candidate**

  **Request for Testing Accommodations**  
Attention-Deficit/Hyperactivity Disorder

To be completed by Chief Examiners

\_\_\_\_\_

Candidate's Last 4 SSN/SIN

**Section 1: To be completed by GED Candidate**

  **Request for Testing Accommodations**  
Learning and Other Cognitive Disabilities

To be completed by Chief Examiners

\_\_\_\_\_

Candidate's Last 4 SSN/SIN

**Section 1: To be completed by GED Candidate**

  **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**

# Forms

**Request for Testing Accommodations**  
Physical/Chronic Health Disability  
6369

*(To be completed by Chief Examiner)*  
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: \_\_\_\_\_  
 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 \_\_\_\_\_

**Request for Testing Accommodations**  
Attention-Deficit/Hyperactivity Disorder  
5297

*(To be completed by Chief Examiner)*  
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: \_\_\_\_\_  
 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 include 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 evaluated. Documentation will be viewed as sufficiently current if it has been completed within the last 3 years. 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:    /    /     
 License 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:    /    /   

ADD/ADHD - page 1 of 4

**Request for Testing Accommodations**  
Learning and Other Cognitive Disabilities  
8051

*(To be completed by Chief Examiner)*  
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: \_\_\_\_\_  
 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**

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**Please indicate your role:**  Professional Diagnostician  Advocate

Name of Professional Making Diagnosis (please print): \_\_\_\_\_  
 Phone Number: (\_\_\_\_) \_\_\_\_\_ Date of Assessment:    /    /     
 License 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:    /    /   

LD - page 1 of 5

**Request for Testing Accommodations**  
Emotional/Mental Health  
6369

*(To be completed by Chief Examiner)*  
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: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State/Province/Territory: \_\_\_\_\_ ZIP/Postal Code: \_\_\_\_\_  
 Phone Number: (\_\_\_\_) \_\_\_\_\_

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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**

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 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 include 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 evaluated. Documentation will be viewed as sufficiently current if it has been completed within the last 3 years. 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:    /    /     
 License 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:    /    /   

EMH - page 1 of 3

**Request for Testing Accommodations**  
Learning and Other Cognitive Disabilities  
8051

*(To be completed by Chief Examiner)*  
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: \_\_\_\_\_  
 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.

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 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**

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**Please indicate your role:**  Professional Diagnostician  Advocate

Name of Professional Making Diagnosis (please print): \_\_\_\_\_  
 Phone Number: (\_\_\_\_) \_\_\_\_\_ Date of Assessment:    /    /     
 Highest Degree and Area of Specialization: \_\_\_\_\_  
 License Number: \_\_\_\_\_ Expiration:    /    /    State/Province/Territory: \_\_\_\_\_  
 Name of Advocate (please print): \_\_\_\_\_  
 Relationship to Candidate (please print): \_\_\_\_\_  
 Phone Number: (\_\_\_\_) \_\_\_\_\_  
 Professional Making Diagnosis or Advocate's Signature: \_\_\_\_\_  
 Date:    /    /   

LD - page 1 of 5

# Who is an advocate?

An adult who helps the GED candidate when he/she:

- physically can not complete the form(s)
- is not sure how to complete the form
- is unable to get the form completed by a diagnosing professional
- has difficulty following through on a multi-step process.

## If the student has a copy of the report, an advocate . . .

- can transcribe all the information requested onto the form (from originally signed report);
- attach a copy of the report to the accommodation request; and
- complete the advocate information as requested in section 3.



# What if...?

- The diagnosing professional is no longer available due to retirement, a move, etc. AND the student has a copy of the report?

OR

- Older documentation is all the candidate can provide?



# Answer

- Another diagnostician may state the disability has not changed.
- Older documentation will be considered if that is all the candidate can provide without undue burden or expense.

# All Forms Same For

**Section 1**

**Section 2**

**Section 4**

# Section 1



8051

## Request for Testing Accommodations Learning and Other Cognitive Disabilities

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: \_\_\_\_

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 1

### Every request for testing accommodations

**Release of Information:** I grant permission to release my medical or psychological records to the Testing Service and its designees to document my request for accommodation. If the candidate is under 18 years of age, a parent or guardian's signature is also required.

*Candidate's Signature*

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

# Section 2

## 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 4



8051

## Request for Testing Accommodations Learning and Other Cognitive Disabilities

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: \_\_\_\_\_

# Section 4

Returned for more information.

Date Returned:      /      /       
MM      DD      YYYY

Reasons for returning request:

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Request forwarded to GEDTS for review (explain reasons below.)

Date Forwarded:      /      /       
MM      DD      YYYY

Reasons for forwarding request to GEDTS for review:

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\_\_\_\_\_  
*GED Administrator's Signature*

\_\_\_\_\_  
*Telephone Number*

\_\_\_\_\_  
*Date*

# Section 3 - All Forms Different

## ■ Physical Chronic Health Disability

- Section 3 requires the diagnostician's name, licensure number, and licensure expiration date.
- Section 3A requires a letter on official letterhead stating the diagnosis and the functional limitations.

## ■ Emotional/Mental Health Disability

- **Same as above** *except there should be evidence of continuing medication.*

## ■ Attention-Deficit /Hyperactivity

- There is more direction on this section than the other forms.
- Diagnostician must be trained in diagnosing ADD/ADHD

## ■ Learning/Cognitive Disability

- This requires specific assessments completed by a diagnostician.
- The requested accommodation must fit the disability.

# GED Test Accommodations

DISABILITY	LICENSED OR CERTIFIED PROFESSIONAL
<b>Learning Disability</b>	<ul style="list-style-type: none"><li>• Psychologist</li><li>• School Psychologists</li><li>• Educational Specialist with Advanced Training</li></ul>
<b>Attention-Deficit/Hyperactivity Disorder</b>	<ul style="list-style-type: none"><li>• Psychologists</li><li>• Psychiatrists</li><li>• Physicians</li></ul>
<b>Physical /Chronic Health Disability</b>	<ul style="list-style-type: none"><li>• Physicians</li><li>• Specialists in a particular area such as Audiologists</li></ul>
<b>Emotional /Mental Disabilities</b>	<ul style="list-style-type: none"><li>• Psychiatrists</li><li>• Psychologists</li><li>• School Psychologists</li><li>• Licensed Professional Counselors</li></ul>

# GED Test Accommodations

DISABILITY	ACCOMMODATIONS*
<b>Dyslexia</b>	<ul style="list-style-type: none"> <li>• Extended Time</li> <li>• Audiocassette</li> </ul>
<b>Dysgraphia</b>	<ul style="list-style-type: none"> <li>• Extended Time</li> <li>• Scribe</li> </ul>
<b>Dyscalculia</b>	<ul style="list-style-type: none"> <li>• Extended Time</li> <li>• Calculator</li> </ul>
<b>Attention-Deficit/Hyperactivity Disorder (ADHD)</b>	<ul style="list-style-type: none"> <li>• Extended Time</li> <li>• Frequent Breaks</li> <li>• Private Room</li> </ul>
<b>Physical/Chronic Health Disabilities**</b>	<ul style="list-style-type: none"> <li>• Extended Time</li> <li>• Private Room</li> <li>• Audiocassette</li> <li>• Scribe</li> <li>• Large Print</li> <li>• Frequent Breaks</li> <li>• One Test Per Day</li> </ul>

*\*accommodations usually granted with documentation*

*\*\*accommodation depends upon specific disability*

# Section 3: Physical and Chronic Health

## 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 evaluated.

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:* \_\_\_\_\_

PCH - page 1 of 3

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

# Section 3: Physical and Chronic Health

## Section 3A: Physical/Chronic Health Disability

To request accommodations for a Physical/Chronic 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 must include a letter on official letterhead, signed by a qualified professional, stating the diagnosed disability and providing supporting documentation of this disability.**

Documentation for those candidates that have a Physical/Chronic Health disability should reflect current functional limitations.

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

### Condition:

Visual Impairment - Describe: \_\_\_\_\_

Hearing Impairment - Describe: \_\_\_\_\_

Mobility Impairment - Describe: \_\_\_\_\_

Other Impairment - Describe: \_\_\_\_\_

Functional Limitations: \_\_\_\_\_

Recommended Accommodations: \_\_\_\_\_

Rationale for Accommodations: \_\_\_\_\_

# Activity



# Section 3: Emotional & Mental Health

## 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 evaluated. *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

# Section 3: Emotional & Mental Health

## 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 3: Emotional & Mental Health

## 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.

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EMH - page 2 of 3

# Activity



# Section 3: Attention Deficit Hyperactivity Disorder

## 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 evaluated. Documentation will be viewed as sufficiently current if it has been completed within the last 3 years. 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: \_\_\_\_\_

ADD/ADHD - page 1 of 4

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

# Section 3A-1: Attention Deficit Hyperactivity Disorder



## Request for Testing Accommodations Attention-Deficit/Hyperactivity Disorder

To be completed by Chief Examiners.

\_\_\_\_\_  
Candidate's Last 4 SSN/SIN

### Section 3A: Attention-Deficit/Hyperactivity Disorder

#### Attention-Deficit/Hyperactivity Disorder (ADHD)

To request accommodations for ADHD, the current level of impairment and resulting functional limitations must be clearly documented, as well as the history of those impairments and limitations. **Documentation must include a letter on official letterhead, signed by a psychiatrist, medical doctor, or psychologist who specializes in the diagnosis of ADHD, stating the diagnosis of ADHD and providing supporting diagnostic evidence of this disability.**

Diagnostic evidence may include a developmental history that defines symptom onset, as well as the results from a specific test of attention such as the TOVA Gordon Diagnostic Battery or the CPT (Conners' Continuous Performance Test).

Information presented must clearly document how the ADHD substantially limits the candidate's current ability to take the GED Tests under standard conditions, and identify the accommodations that are requested in light of those limitations. Further, the documentation must confirm that the ADHD symptoms are not due to other emotional/mental health factors. A DSM-IV diagnosis must be included with the certifying professional's or advocate's signature attesting to the diagnosis of ADHD.

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

# Section 3: Attention Deficit Hyperactivity Disorder

**DSM-IV Diagnosis Code:** Indicate all that apply.

- 314.01 Attention-Deficit/Hyperactivity Disorder Combined Type
- 314.00 Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type
- 314.01 Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulse Type
- 314.9 Attention-Deficit/Hyperactivity Disorder, Not Otherwise Specified

Functional Limitation(s): \_\_\_\_\_  
\_\_\_\_\_

Recommended Accommodation(s): \_\_\_\_\_  
\_\_\_\_\_

Rationale for Accommodation(s): \_\_\_\_\_  
\_\_\_\_\_

# Section 3C: Attention Deficit Hyperactivity Disorder

Provide any additional information that may assist with the approval of the request.

## 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.

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# Activity



# Section 3: Learning & Other Cognitive Disabilities

## 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 evaluated. *Documentation will be viewed as sufficiently current if it has been completed within the last 5 years. 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

Highest Degree and Area of Specialization: \_\_\_\_\_

License Number: \_\_\_\_\_ Expiration: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ State/Province/Territory: \_\_\_\_\_  
MM DD YYYY

Name of Advocate (please print): \_\_\_\_\_

Relationship to Candidate (please print): \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Professional Making Diagnosis or Advocate's Signature: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY







# Section 3B: Learning & Other Cognitive Disabilities

<b>Test Used:</b>		
<input type="checkbox"/> SB-IV	<input type="checkbox"/> SB-V	
<b>Subtest</b>	<b>Standard Score</b>	<b>Estimated Age Score</b>
Verbal Reasoning:	_____	_____
Abstract/Visual Reasoning:	_____	_____
Quantitative Reasoning	_____	_____
Short-Term Memory:	_____	_____
<b>Test Composite:</b>	_____	_____
<hr/>		
<b>Test Used:</b>		
<input type="checkbox"/> WJ-III, Cog		
<b>Subtest</b>	<b>Percentile Rank (Age)</b>	<b>Standard Score (Age)</b>
Verbal Comprehension:	_____	_____
Visual-Auditory Learning	_____	_____
Numbers Reversed:	_____	_____
Visual Matching:	_____	_____
Sound Blending	_____	_____
Spatial Relations:	_____	_____
Concept Formation:	_____	_____
		GIA Score: _____

# Section 3C: Learning & Other Cognitive Disabilities

Identify a disability and provide DSM-IV Codes

## Section 3C: Diagnosed Disability

The professional diagnostician or advocate must select all appropriate diagnosed disabilities.

### Specific Learning Disabilities (check all that apply)

- Reading Disability (identify: \_\_\_\_\_)
- Mathematics Disability (identify: \_\_\_\_\_)
- Written Language Disability (identify: \_\_\_\_\_)
- Other cognitive disabilities (list all that apply):

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

DSM-IV Code(s): \_\_\_\_\_

# Section 3E: Learning & Other Cognitive Disabilities

Provide any additional information that may assist with the approval of the request.

## Section 3E: 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.

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# Activity



# Cost of Accommodated Testing

- Use OVR if Employment Related
- Use Contacts in Community—Ophthalmologists, etc.
- Use Local Resources to Finance
- KYAE and KPA

# Test Center Cost

- Accommodated Testing is *VERY* Expensive
- Recognize that Accommodated Testing Means Multiple Sessions
- Charge is \$40, but Cost is \$1,000 to \$1,500
- Test Fee For All Must Cover Accommodated Testing.