

Request for Testing Accommodations Emotional/Mental Health

To be com	pleted	by Cł	nief Ex	aminers
				_

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 it additional infor	•			
Last Name: Social Security or Social Insurance Number: Address:	First Name:			
Social Security or Social Insurance Number:	<u> </u>	Birth Date:/	/	Age:
Address:		MM	DD YYYY	
City: 5	State/Province/Territory: _	ZIP/Posta	l Code:	
City: 5 Phone Number: ()				
Release of information: If you are under 18 years				
I grant permission to school officials and my he my medical or psychological records to the GEI for testing accommodations.				
Candidate's Signature	Parent or Guardian's S	ignature (if appro	priate)	
Section 2: To be completed	by GED Chief E	xaminer		
Please review the form to be certain all sections have the top right corner of each page of this form. Missir	e been completed. Record the ng information may delay the	last four digits of th		
date the form before sending it to your GED Admini Chief Examiner Name:		-Digit Center ID #:		
		Digit Center 12 ".		
Center Name:	EAY Number: (
E-mail:	rax Number. (
I have reviewed this application and confirm that				
GED Chief Examiner's Signature		Date		
Section 3: To be completed b	y Professional	Diagnostic	ian or	Advocate
This section must be completed by the professional diagnostician's rewith a candidate's school district. An advocate is so request testing accommodations. The professional's assessment tests must include a clear diagnosis and candidate's ability to take the tests under standard coproperly evaulated. <i>Documentation will be viewed as</i> solder documentation will be considered if that is all	port if the professional is una meone other than the profess report must indicate certifica provide information on curre onditions, so that the rational ufficiently current if it has been	vailable or documer ional diagnostician vation or licensure. Do nt functional limitate for the requested a completed within the license.	ntation is cur who helps the ocumentation ions that mi accommodat last 6 months	rently on file ne candidate n and ght affect the ion can be . However,
Please indicate your role: Professional Dia	agnostician Advoca	ate		
Name of Professional Making Diagnosis (please				
Phone Number: ()	Date of Assessment: _	///	20/	
Licensure or Certification: Expiration Date: State/Province/Territory: Num	//	Specialty:		
Name of Advocate (please print):				
Relationship to Candidate (please print):				
Phone Number: ()				
Professional Making Diagnosis or Advocate's S	Signature:			_
EMH - page 1 of 3	Date: / /	YYYY		•



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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.)	
OSM-IV Code:	Diagnosis:	
Condition: unctional Limitations:		
ecommended accommodati	n(s):	
ationale for accommodation	s):	
ection 3B: Reque	sted Accommodations	
Please identify those accom-	nodations that support the diagnosed disability.	
Extended Time (please s	pecify): 1-1/2 times 2 times Other:	
2 times Oth		
2	dation requires practice. Candidates should have an opportunity to practice using e Test, Audiocassette Version prior to scheduled testing date.	
Braille		
Scribe		
Calculator for Part II		
☐ Talking Calculator for E	tire Mathematics Test	
Private Room		
Supervised Breaks (spec	fy in minutes):	
Uninterrupted testing	me: minutes, break time: minutes	
Other:		
ection 3C: Other	nformation and Supporting Documents	
, ,	ed by the candidate or by his or her certifying professional or advocate. Provide any rish 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.



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To	be completed by Chief Examiners
	andidate'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.

Supervised Breaks (specify in minutes): Uninterrupted testing time: m	inutes, break time:	minute	s
_	inutes, break time:	minute	S
Other:			
_			
Returned for more information.	Date Returned:	/ /	
Reasons for returning request:	Date Returned:	DD YYYY	_
Reasons for returning request.			
Request forwarded to GEDTS for review (explain a	reasons below.)	Date Forwarded	
		Date Forwarded	://
Request forwarded to GEDTS for review (explain a		Date Forwarded	
		Date Forwarded	