Commission on Rehabilitation Counselor Certification
1699 East Woodfield Road, Suite 300, Schaumburg, IL 60173
Phone: (847) 944-1325--Fax: (847) 944-1346

Exam Accommodation Request

This request has three parts to be completed by:

1) Candidate
2) Physician or other Licensed Medical/Neuropsychological Professional
3) Assisted Technology Specialist

NAME	First	Middle Initial	Last	Former Name (if applicable)

ADDRESS				
Street	Apartment/Suite	City	State	Zip Code

1. Information supplied by Candidate

Do you have a documented, diagnosed disability that may create a barrier to sit for a 150-multiple choice, computerized exam for up to 3.5 hours of exam content and separate time for a brief tutorial and post-test evaluation?	☐ Yes	☐ No

Can you provide written documentation of the disability?	☐ Yes	☐ No

Can you provide documentation that demonstrates that your requested accommodations have been provided in similar or same test situations in the past? (Similar/same means a computerized, multiple choice exam in a cubicle setting with no noise distractions. Length of previous exam also required).	☐ Yes	☐ No

Do you have assistive devices that you utilize on a regular basis that would be helpful in this testing situation?	☐ Yes	☐ No

Requested Accommodation(s)		
Adjustable Contrast (Documentation required from an ophthalmologist or vision specialist showing specific contrast needed for your condition)	☐ Yes	☐ No
Adjustable workstation = Height Table	☐ Yes	☐ No
Anti-Glare Screen (attaches to monitor to reduce glare)	☐ Yes	☐ No

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Beverage (Applicant supplied. Medical documentation demonstrating need and reason)	☐ Yes	☐ No
Extra Time--one and one half (Total 5.25 hours) (Must provide documentation of amount of extra time given previously for same or similar type exams--See below*)	☐ Yes	☐ No
Extra Time--Double time (Total of 7 hours) (Must provide documentation of amount of extra time given previously for same or similar type exams--See below*)	☐ Yes	☐ No
JAWS (Job Access with Speech) (Must provide documentation from AT specialist showing proficiency with the use of JAWS or college instructor stating your proficiency with JAWS)	☐ Yes	☐ No
Separate Room & Live Reader (Must provide documentation from a medical professional and/or Assistive Technology specialist as to the need for a live person in place of a screen reader and previous provision of this accommodation)	☐ Yes	☐ No
Separate Room & Scribe/Recorder (Individual to operate mouse or keyboard) (Must provide medical documentation from a physician or physical therapist stating the need for this accommodation in place of a track ball mouse or Dragon)	☐ Yes	☐ No
Separate room (Only provided for persons requiring a scribe or documented by a medical or neuropsychological professional and documentation that this accommodation has been provided previously for a same or similar exam)	☐ Yes	☐ No
Sign Language Interpreter (Must provide documentation that this accommodation was provided previously for a same or similar exam. There is very limited engagement with testing center personnel. --See below**)	☐ Yes	☐ No
Touch Pad Mouse (Must provide medical documentation from a physician or physical therapist)	☐ Yes	☐ No
Track Ball Mouse (Must provide medical documentation from a physician or physical therapist)	☐ Yes	☐ No
Screen magnifier (This option is available on the browser by clicking + or - buttons)		
Other (please explain)-	☐ Yes	☐ No

**** Extra time can only be granted if documentation provided is from a college instructor who can show this accommodation was provided for exams of same or similar type. To be of same or similar type, means the exam must have been a computerized, multiple choice, time-limited exam where no exam taker was allowed to ask questions. The exam did not have any essay or discussion questions. Note: One scheduled break is provided at mid-point of the exam.***

*****The ADA allows for comparable accommodations in place of an American Sign Language (ASL) interpreter. The environment for this exam has minimal contact with any other person. The only time communication between a candidate and another person should occur during the test period is:***

1. ***Check-in: Upon entry to the testing center to notify the staff you are present.***
2. ***If you experience the need for computer assistance or to take a break.***
3. ***To find the restroom.***
4. ***To notify staff you have completed the exam.***

All of the above can be done via a notepad or the candidate may bring a family member to wait in the test center reception area and provide the minimal translation that may be needed.

View of an Authorized Testing Center Tour:
https://www.pearsonvue.co.uk/Test-Owner/Deliver/Test-center/PPC-photo-tour.aspx

The space in a typical testing center shows the separations in cubes and spread-out seating compared to standard classroom settings. The testing room is quiet (no speaking is allowed), noise cancellation phones are provided when requested in advance.

For more details about CRCC ADA accommodations, refer to the CRC Certification Guide.
https://www.crccertification.com/filebin/pdf/CRCCertificationGuide.pdf

CRCC
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2. Information supplied by Physician or other Medical/Neuropsychological Professional

The above-named candidate has applied to sit for the Certified Rehabilitation Counselor exam. This exam consists of 175-multiple choice questions. The exam is delivered via computer and is completely accessible with all forms of assistive technology and/or devices. Each candidate is provided a private cubicle and privacy headphones are available. There is no verbal or written communication with other persons in the room during the exam. There is a time limit of 3.5 hours to complete the exam content, as well as separate time for pre-test tutorials and post-test evaluation for a total of 4 hours.

The above-named person has requested the selected accommodations that require medical or neuropsychological confirmation of need. Your signature testifies that you provide care, or have provided care, to the above-named person and that the requested accommodations are reasonable and necessary for the type of exam and environment described above.

First date of treatment: _____ Last date of treatment: _____

Specific disability condition treated: _____

Comments: _____

_____

_____

_____ _____

Printed Name of Professional Date

_____

Signature of Professional

Name, address, and phone of above professional:

_____

_____

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3. Information supplied by an Assisted Technology Specialist

The above-named candidate has applied to sit for the Certified Rehabilitation Counselor exam. This exam consists of 175-multiple choice questions. The exam is delivered via computer and is completely accessible with all forms of assistive technology and/or devices. Each candidate is provided a private cubicle and privacy headphones are available. There is no verbal or written communication with other persons in the room during the exam. There is a time limit of 3.5 hours to complete the exam, as well as separate time for pre-test tutorials and post-test evaluation for a total of 4 hours.

The above-named person has requested the selected accommodations that require educational facility or assistive technology specialist confirmation of need. Your signature testifies that you provide educational or technology instruction and/or assessments, or have provided such, to the above-named person and that the requested accommodations are reasonable and necessary for the type of exam and environment described above. Please attach verification that the accommodations requested have been provided to the above-named person for previous exams that were of similar or same type. For Assistive Technology Specialists, your signature verifies that the candidate has achieved proficiency in the technology accommodation requested above.

Type of exam: Multiple choice Essay Computerized Paper Other

Length of time allowed for exam: _____

Technology or other accommodations utilized during the exam: _____

Specific disability condition: _____

Comments: _____

_____

_____

_____ _____

Printed Name of Professional Date

_____

Signature of Professional

Name, address, and phone of above professional:

_____

_____

EXAMPLE FORM – the Eye Examination report should include the information below.

Confidential Eye Examination Report

Eye Examination Date: _____
Patient Name: _____
Patient Address: _____
Date of Birth: _____ Patient Telephone Number: _____

******* VISUAL ACUITY INFORMATION *******

Distant Vision: Right Eye Without Correction _____ Left Eye Without Correction _____
Right Eye Best Correction Left Eye Best Correction
Visual Field: Right Eye (OD) _____ Left Eye (OS) _____

IS THE PATIENT LEGALLY BLIND? **Yes** **No**

If the patient is not legally blind at present, could the patient become legally blind due to the progressive nature of the condition/pathology? **Yes** _____ **No** _____

Present ocular condition responsible for visual impairment
OD _____
OS _____

Intraocular Pressure: Right Eye Left Eye

******* PROGNOSIS AND RECOMMENDATION *******

Recommended Treatment **(Including CPT Codes)**: _____

_____

_____

Is Re-Examination Advised? Yes _____ No _____ If So, Date of Re-Examination _____

_____ _____
Name of Eye Care Professional **(Please Print)** Signature of Eye Care Professional

Practice Name and Address of Eye Care Professional Telephone Number
Name of Counselor _____ District Office _____

SCCB VR App. 6.1 Report of Eye Examination (REV 12/11)