# Documentation of Disability-Related Needs Form

This form must be completed by a licensed health care provider or appropriate professional. The nature of the disability and the specific accommodations requested should be included.

I have known \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ since \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*[Name of Candidate] [Date]*

in my capacity as a(n) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

*[Professional Title]*

The candidate discussed with me the nature of the tests being administered. It is my opinion that because of this applicant’s disability described below, he/she should be accommodated by providing the special arrangements listed on the Special Accommodations Request Form.

|  |  |
| --- | --- |
| **Recommended Accommodation(s)** |  |
| **Comments** |  |
| **Name** |  |
| **Title** |  |
| **Organization** |  |
| **License # (if applicable)** |  |
| **Phone** |  |
| **Email** |  |
| **Signature** |  |
| **Date** |  |

Submit this form, along with the original request, to [fi360support@broadridge.com](mailto:fi360support@broadridge.com).