Texas Behavioral Health Executive Council
1801 Congress Ave, Ste 7.300
Austin, TX 78701
(512) 305-7700
www.bhec.texas.gov

EPPP Testing Accommodations Request Form

Please refer to the BHEC EPPP Testing Accommodations Guidelines prior to completing this form.

Section A: To be completed by the Exam Candidate

First Name _____ Last Name _____

Address _____

City _____ State_____ Zip Code_____

Date of Birth_____ Last 4 SSN _____

Phone No. _____

Email Address _____

Exam Type: ☐ EPPP

1. Provide a written description of your disability and functional limitations resulting from the disability.

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2. **Prior Testing Accommodations:** Document testing accommodations approved for prior standardized testing (e.g. SAT, GRE, college exams, etc.) If no prior accommodation exists, the qualified professional should explain why no accommodations were given in the past and are needed now.

3. Do you have a formal medical or mental health diagnosis made or confirmed within the last five years by a licensed professional qualified to make the diagnosis describing the need for specific accommodation? ☐ Yes ☐ No

4. Do you have a formal psychiatric disability diagnosis made or confirmed within the last 12 months by a licensed professional qualified to make the diagnosis describing the need for specific accommodation? ☐ Yes ☐ No

Candidate's Signature _____ Date _____

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Section B. To be completed by a Qualified Professional

This Section of the Request Form must be completed by a qualified professional who has recently evaluated the examination candidate identified in Section A of this form.

Candidate Name _____ **Date of Birth** _____

1. **Diagnosed Disability of the Candidate:**

2. **Disability Impact:** Describe how impairment substantially limits the candidate's major life activities (such as seeing, hearing, learning, reading, concentrating, or thinking) or a major bodily function (such as the neurological, endocrine, or digestive system) when compared to most people in the general population:

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3. Recommended Testing Accommodations based on the Candidate's disability(ies) and impairment:

☐ Extended Time: Standard Time + 50% (Time and a Half)

☐ Extended Time: Standard Time + 100 % (Double Time)

☐ Extended Time: Additional 30 Minutes

☐ Frequent Breaks *(does not stop the clock)*

☐ Separate Room ☐ Reader ☐ Scribe ☐ Zoom Text

☐ Locker Access (snacks/medications) ☐ Medical Device/Supplies

☐ Other:

3a: Explanation why accommodations listed above is necessary to minimize impact of the disability while taking the high stakes examination.

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I hereby certify that the above information is true and is given pursuant to the authorization to release information by the above-named candidate. I attest I have specific training and experience in the assessment, diagnosis, and treatment of the disability identified above. I hereby certify I personally completed this form and provided specific recommendations for reasonable accommodation for the high stakes exam noted above. I understand that the Texas Behavioral Health Executive Health Council may contact me to obtain additional information or obtain an independent assessment by a second professional.

Signature of Qualified Professional	Date	
Print Name of Qualified Professional	Title	
Address	City, State, Zip Code	
Phone Number	Email Address	
Type of Professional	License/Cert No.	Expiration Date