REQUEST FOR SPECIAL EXAMINATION ACCOMMODATIONS

If you have a disability covered by the Americans with Disabilities Act, please complete this form and ask your provider to complete and send in the *Documentation of Disability-Related Needs* on the next page at least 45 days prior to your preferred examination date. The information you provide and any documentation regarding your disability and your need for accommodation in testing will be treated with strict confidentiality.

CANDIDATE INFORMATION

Date of Birth: _____

_____
Name (Last, First, Middle Initial, Former Name)

_____
Mailing Address

_____

_____
City State Zip Code

_____
Daytime Telephone Number and Email Address

SPECIAL ACCOMMODATIONS

I am requesting the following special accommodations for the board certification examination in Music Therapy.

Please provide (check all that apply):

_____ Text to Speech
_____ Extended testing time (time and a half)
_____ Reduced distraction environment
_____ Please specify below if other special accommodations are needed.

_____

_____

_____

The following professional will be completing and sending my Documentation of Disability-Related Needs form to the CBMT Office:

_____

Signed:_____ **Date:**_____

Applicant please send this completed form to:
examdocs@cbmt.org
If you have questions, call the CBMT office at 800-765-2268.

DOCUMENTATION OF DISABILITY-RELATED NEEDS

This form must be completed and submitted directly to CBMT by the appropriate professional (education professional, physician, psychologist, or psychiatrist). Forms submitted by the candidate will not be accepted. This requirement ensures that CBMT receives the documentation needed to provide the required accommodations. *Documentation must be dated no more than five (5) years before the accommodation request date.*

PROFESSIONAL DOCUMENTATION

I have known _____ since _____ / _____ / _____ in my capacity as a
Candidate Name Date

_____.
My Professional Title

The candidate discussed with me the nature of the examination to be administered. It is my opinion that, because of this candidate's disability described below, he/she should be accommodated by providing the special arrangements listed below.

Forms that do not state the diagnosed disability will not be accepted.

_____

_____

_____

_____

_____

Signed:_____Title:_____

Printed Name:_____

Address: _____

_____

Telephone Number:_____ Email Address:_____

Date:_____ License # (if applicable):_____

Appropriate Professional (education professional, physician, psychologist, or psychiatrist) please send this completed form to:

examdocs@cbmt.org or mail to:
Certification Board for Music Therapists
506 E. Lancaster Ave., Suite 102
Downingtown, PA 19335

If you have questions, call the CBMT office at 800-765-2268.