GED Test Accommodations Request Form

Section 1: To be completed by GED Test-Taker

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 GED Administrator. The GED Administrator will review the form and let you know if additional information is required.

Last Name: _____First Name: _____

Birth Date: _____/_____/_____ Age: _____
MM DD YYYY

Address:_____

City: _____ Province: _____ Postal Code: _____

Phone Number: (_____) _____ Email: _____

Release of information: I grant permission to school officials and my healthcare provider(s) to release my education-related records and/or my medical or psychological records to the GED Testing Service and its designees in connection with my request for testing accommodations.

_____

Test-Taker Signature ***Date (dd-mm-yyyy)***

Section 2: To be completed by the Certified Professional or Advocate

This section must be completed by the **certified professional**. Alternatively, **an advocate** may complete this section using information from the professional diagnostician's report if the professional is unavailable or documentation is currently on file with a test-taker's school district. An **advocate** is someone other than the professional diagnostician who helps the test-taker request testing accommodations. The professional's report must indicate certification or licensure. **Documentation and/or assessment tests must be included with this form**. Diagnosis or information on current functional limitations that might affect the test-taker's ability to take the tests under standard conditions must be clear, so that the rationale for the requested accommodation can be properly evaluated. ***Documentation will be viewed as sufficiently current if it has been completed within the last 3 years.*** However, older documentation will be considered if that is all that the test-taker can provide without undue burden or expense.

Please indicate your role: ☐ Professional Diagnostician ☐ Advocate

Professional Making Diagnosis Name (please print):

_____

Phone Number: (_____) _____ Date of Assessment: _____/_____/_____
MM DD YYYY

OR

Advocate Name (please print): _____

Relationship to Test-taker (please print): _____

Phone Number: (_____) _____

Professional Making Diagnosis or Advocate's Signature: _____

Date: _____/_____/_____
MM DD YYYY

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Section 3A: Medical Condition or Diagnosed Learning Disability

To be completed by the professional diagnostician or advocate helping you complete this form

The professional diagnostician or advocate must select all appropriate diagnosed condition or learning disabilities or physical impairment.

To request accommodations for an impairment or a diagnosed disability, the current level of impairment and resulting functional limitations must be clearly documented, as well, as the 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 certified professional who specializes in the diagnosis of the disability, and providing supporting documentation of this disability.

Supporting documentation on certified professional 's letterhead ATTACHED. (Mandatory)

Medical Condition: (check all that apply)

☐ Visual Impairment – Describe: _____

☐ Hearing Impairment – Describe: _____

☐ Mobility Impairment – Describe: _____

☐ Other Impairment – Describe: _____

Learning Disability: (check all that apply)

☐ Reading Disability (identify): _____

☐ Mathematics Disability (identify): _____

☐ Written Language Disability (identify): _____

☐ Other cognitive disabilities (list all that apply):

_____

_____

_____ DSM-IV Code(s): _____

Section 3B: Requested Accommodations

Please identify those accommodations that support the diagnosed disability.

☐ Extended Time (please specify): ☐ 1-1/2 times ☐ 2 times Other: _____

☐ Audiocassette (tone-indexed) (requires extended testing time, generally double time)

☐ 2 times ☐ Other: _____

The use of this accommodation requires practice. Test-takers should have an opportunity to practice using an Official GED Practice Test, Audiocassette Version prior to the scheduled testing date.

☐ Braille

☐ Scribe

☐ Calculator for Part II

☐ Private Room Supervised Breaks (specify in minutes):

Uninterrupted testing time: _____minutes Break time: _____minutes

☐ Other: _____

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Section 3C: Other Information and Supporting Documents

This section may be completed by the test-taker or by his or her certifying professional or advocate. Provide any additional information you wish to be considered when this request for accommodations is reviewed.

_____

_____

_____

Please return completed GED Test Accommodations Request form (with supporting documentation) to:

Email: GED@novascotia.ca

Mailing Address:
PO Box 697
Halifax, NS, B3J 2T8

Office Location:
Maritime Centre
1505 Barrington Street, 4th Floor,
Halifax, NS, B3J 3K5

For office use only:
Approval by GED Administrator

Approval: Yes No

Signature (initials):

Date: (dd-mm-yyyy)