



NATIONAL BOARD FOR  
CERTIFIED COUNSELORS®



CENTER FOR  
CREDENTIALING  
& EDUCATION™

## Special Examination Accommodation Request Form For NBCC/CCE Certification and Credentialing Candidates

The National Board for Certified Counselors, Inc. (NBCC) and the Center for Credentialing & Education, Inc. (CCE) provide appropriate accommodations for individuals with disabilities related to NBCC and CCE Examination administrations. This form may be used by candidates with disabilities to request a special test accommodation(s).

The existence of a disability does not automatically necessitate an accommodation. Consistent with the Americans with Disabilities Act (ADA), a disability is a physical or mental impairment that substantially limits a major life activity or bodily function. NBCC/CCE will review all candidate special test accommodation requests, and make a decision approving or denying the requested accommodation(s).

All test accommodation approval determinations by NBCC/CCE are made consistent with the [Special Examination Accommodations Policy](https://www.nbcc.org/exams/accommodations), which can be reviewed on the NBCC website, located at: <https://www.nbcc.org/exams/accommodations>.

### A. Examination Candidate Information

This Section A of the Special Examination Accommodation Request Form must be completed by the candidate. Section B of the Request Form must be completed by a qualified professional who has recently evaluated the candidate with respect to the identified disability(ies).

**Candidate Name:**

**Candidate ID Number:**

**Candidate Address:**

**Examination for which Candidate is requesting accommodation(s):**

**Disability(ies):**

**Requested Accommodation(s):**

## B. Qualified Professional Use Only

**This Section of the Request Form must be completed by a qualified professional who has recently evaluated the examination candidate identified above.** A qualified professional is an individual, who possesses appropriate expertise in evaluating and assessing the disability for which the accommodation is sought, and who is licensed or otherwise properly credentialed. Only a credentialed professional who has assessed the candidate, and understands the impact of the disability(ies) on the participant's ability to participate in the examination, may complete this Section of the Form.

**1. Diagnosed Disability(ies) of the Candidate:**

**2. Date of Individualized Assessment of the Candidate:**

**3. Disability Assessment Method:**

**4. Disability Impairment:** Please describe how the impairment substantially limits the candidate's major life activities:

**5. In-Person Test Administration/Recommended Accommodation(s):** Based on the Candidate's disability(ies) and impairment, please identify the accommodation(s) you recommend to make the Examination, taken at an in-person testing center, accessible for this candidate:

\_\_\_\_\_ Additional Examination Time (Please specify the amount of extra time): \_\_\_\_\_

\_\_\_\_\_ Human Reader

\_\_\_\_\_ Human Scribe

\_\_\_\_\_ Enlarged Text

\_\_\_\_\_ Screen Magnification Technology

\_\_\_\_\_ Job Access With Speech (JAWS) Screen Reader Software

\_\_\_\_\_ Sign Language Interpreter

\_\_\_\_\_ Separate Testing Environment/Private Test Room

\_\_\_\_\_ Scheduled Breaks (With Paused Examination)

\_\_\_\_\_ Braille Text

\_\_\_\_\_ Special Seating (Please describe):

- \_\_\_\_\_ Glucose Supplies
- \_\_\_\_\_ Medication Access
- \_\_\_\_\_ Personal Care Attendant
- \_\_\_\_\_ Nursing Mother Accommodations
- \_\_\_\_\_ Other accommodation(s) (Please describe):

**6. Internet-Based (Online) Test Administration/ Recommended Accommodation(s):** Based on the Candidate's disability(ies) and impairment, please identify the accommodation(s) you recommend to make the Internet-based (online) Examination accessible for this candidate:

- \_\_\_\_\_ Additional Examination Time (Please specify the amount of extra time): \_\_\_\_\_
- \_\_\_\_\_ Other accommodation(s) (Please describe):

Name and Title of Qualified Professional	License and/or Other Relevant Credentials No.	
State of Licensure and/or Credentials		
Signature of Qualified Professional	Date	
Name of Practice	Phone Number	
Business Address		
City	State	Zip Code
Email Address		