Test Accommodation Request Form

New Request

Please carefully review the ABP's Policies and Procedures for Applicants with Disabilities to ensure that you provide the required documentation from a qualified professional. Submission of incomplete information will delay the processing of your request.

Send your completed form with supporting documentation by the final published deadline to: American Board of Pediatrics, 111 Silver Cedar Court, Chapel Hill, NC 27514, or by email to:
General Pediatrics Certification: gpcert@abpeds.org; Maintenance of Certification: moc@abpeds.org; Subspecialties: sscert@abpeds.org; Subspecialty In-Training Examination: site@abpeds.org.
Applicants will select a computer testing center after a decision has been made on the test accommodation request.

Please type or print.

Accommodations are requested for the following examination:

Examination: _____ Year: _____

1. Your Name: _____
   Last First Middle Initial

2. ABP ID #: _____ (if known)

3. Contact Information: _____
   Daytime Telephone Cell Phone

   _____
   Email Address

4. Nature of Disability:

   ☐ Visual Disability
   ☐ Hearing Disability
   ☐ Learning Disability
   ☐ Attention Deficit/Hyperactivity Disorder
   ☐ Physical Disability
   ☐ Psychiatric/Mood Disorder
   ☐ Other: _____

5. Optional: To support your request, you may attach, in addition to professional documentation, a personal statement describing your disability and its impact on your daily life and educational functioning. If relevant, also describe any current workplace accommodations.

6. How long ago was your disability first professionally diagnosed?

   ☐ less than 1 year ☐ 1–2 years ☐ 2–4 years ☐ 5 or more years

7. What accommodation(s) are you requesting? Accommodation(s) must be appropriate to your disability. *(Check all that apply)*

Certifying, Maintenance of Certification and Subspecialty In-Training Exams:

☐ Assistance with marking answers
☐ Extended testing time
Amount requested as supported by your documentation:_____
(i.e., additional 30 minutes per test session; time and one half, or double time)
☐ Screen magnification
☐ Zoom text
☐ Reader
☐ Individual testing room (for those whose disability necessitates separation from all other examinees)
☐ Special physical accommodations at the site
(special lighting, chair, etc.) _____

☐ Extended Breaks (explain; please be specific)
_____

☐ Other_____

MOCA-Peds:

Extended testing time
Amount requested as supported by your documentation:_____
(i.e., time and one half, or double time to read and answer each test item)

Note: Those who need enlarged font or text for MOCA-Peds may use features on the computer browser to accomplish this; a request for this accommodation does not need to be submitted to the ABP.

8. Have you received classroom or test accommodation(s) in the past?: ◯ Yes ◯ No
If yes, please complete Sections A-C below.

A. Standardized Examinations *(Check all that apply)*
Attach documentation showing the accommodations granted when the examination was administered.

☐ Medical College Admission Test (MCAT) Month/Year: _____
Accommodation(s) received: _____

☐ United States Medical Licensing Exam (USMLE) Month/Year: _____
Accommodation(s) received: _____

☐ Other: _____Month/Year: _____
Accommodation(s) received: _____

B. Medical School/Residency ◯ Yes ◯ No
If yes, provide a statement from your medical school and/or residency training program explaining the type of accommodations made and date approved.

C. College ◯ Yes ◯ No
If yes, accommodation(s) received: _____

9. Authorization:

I certify that the above information is true and accurate. If testing accommodations granted to me include a deviation from the standard testing time schedule, I agree that, from the time I begin the examination until I have completed it, I will not communicate in any way, to the extent possible, with any other individuals taking the examination and I will not communicate in any way with any such individuals about the content of the examination.

Signature _____ Date _____

If clarification or further information regarding the documentation provided is needed, I authorize the ABP to contact the professional(s) who diagnosed the disability and/or those entities which have provided me test accommodations. I authorize such professional(s) and entities to communicate with the ABP in this regard to provide ABP with such clarification and/or further information.

Signature _____ Date _____

Certification of Prior Test Accommodations

To be completed by a medical school official responsible for student disability services.

Please type or print.

Applicant Name: _____

I, _____, hold the position of _____. I certify
Name *Title*

that _____ has officially approved and provided the following test accommodations
Name of Institution

for the above applicant beginning on _____.
Date (Month/Year)

Accommodation(s) provided:

Reason for provision of accommodation(s):

Signature _____ Date _____

Telephone Number _____

Effective 02/01/2006
(revised 2011, 2012, 2016, 8/2018)