



ALPP Special Testing Accommodation Request Form

Certified Lactation Counselor (CLC) Certification

Name _____

Home Address _____

City _____ State _____ Zip _____

Daytime Phone _____

Email Address _____

Date of CLC Certification _____

Location of CLC Examination _____

Candidates with disabilities covered by the Americans with Disabilities Act (or Canadian/Australian equivalent) must complete this form and have an appropriate licensed professional complete the Documentation of Disability-Related Needs Form in order for their accommodations request to be processed

Special Testing Accommodations

I would like to request the following testing accommodation(s):

- Circle answers in test booklet
- Extended testing time (time and a half)
- Large print test. Point size: _____
- Reader
- Separate testing area
- Special seating, please describe: _____
- Wheelchair accessible testing site
- Other special accommodations (please specify):

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Send to:

Academy of Lactation Policy and Practice

Dept Recertification – CLC

PO Box 1288

Forestdale, MA 02644

OR fax to: (508)-833-6070



ALPP
THE ACADEMY OF
**Lactation Policy
and Practice**

Applicant Signature: _____

*** This form must be submitted 4 weeks prior to the start of the CLC Training ***

***** (Office use only) *****

Approved

Denied

Reason:

Date

Authorized ALPP Representative

Send to:

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PO Box 1288

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**ALPP Documentation of Disability-Related Needs by
 Qualified Provider**

Certified Lactation Counselor (CLC) Certification

Name _____

Home Address _____

City _____ State _____ Zip _____

Daytime Phone _____

Email Address _____

Date of CLC Certification _____

Location of CLC Examination _____

This form must be completed by a licensed health care provider or an educational / testing professional. The nature of the disability, identification of the test(s) used to confirm the diagnosis, a description of past accommodations made for the disability, and the specific testing accommodations requested must be included.

Professional Documentation

I have known _____ since _____ as a(n) _____.

(Name of Applicant) (Date)

 (Professional Title)

 (Board Certification)

The applicant discussed with me the nature of the test being administered. It is my opinion that because of this applicant’s disability described below, he/she should be accommodated by providing the special arrangements listed on the Special Testing Accommodation Request Form.

Comments on Disability: _____

Send to:

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 Dept Recertification – CLC
 PO Box 1288
 Forestdale, MA 02644
 OR fax to: (508)-833-6070



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**Lactation Policy
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Signature: _____

Title: _____

Organization: _____

License # (if applicable): _____

Phone Number: _____ Date: _____

Candidate Instructions: Return this form with a copy of the *Special Testing Accommodation Request Form*

Written accommodation requests may also be scanned and submitted via email to: info@alpp.org with the words: *Accommodation Request* in the subject line of the email.

*** This form must be submitted 4 weeks prior to the start of the CLC Training ***

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