ALPP
THE ACADEMY OF
Lactation Policy
and Practice

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):

Send to:

Academy of Lactation Policy and Practice

Department of Certification – CLC

PO Box 2170

South Dennis, MA 02660

OR fax to: (508)-833-6070

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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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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: _____

_____.

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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 ***

Updated 3/4/2021

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