

**OREGON DEPARTMENT OF ENVIRONMENTAL QUALITY  
WASTEWATER SYSTEM OPERATOR CERTIFICATION  
811 SW SIXTH AVENUE, PORTLAND OR 97204  
PHONE: 503-229-5161      FAX: 503-229-6957  
E-MAIL: OPCERT@DEQ.STATE.OR.US**

**REQUEST FOR DISABILITY ACCOMMODATION IN TESTING**

**Test Applicant Information**

The information requested below and any documentation regarding your disability and your need for accommodation in testing will be considered strictly confidential and will not be shared with any outside source without your express written permission.

Applicant Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Telephone \_\_\_\_\_ Last Four Digits SSN \_\_\_\_\_

Accommodations requested for testing. Check all that apply:

- Accessible Testing Site
- Braille       Large Print       Tape
- Reader as accommodation for visual impairment
- Scribe/Amanuensis for visual or motor impairment
- Reader as accommodation for learning disability
- Scribe/amanuensis for learning disability
- Sign Language Interpreter
- Extended Time
  - Time-and-a-half       Double time
  - More the double time (specify) \_\_\_\_\_
- Separate testing area
- Use of computer or other adaptive equipment (specify)  
\_\_\_\_\_
- Other (Please explain)  
\_\_\_\_\_  
\_\_\_\_\_

Comments \_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

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**Some accommodation requests may require additional documentation or fees.**

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**DOCUMENTATION OF DISABILITY RELATED NEEDS**

If you have a learning disability, a psychological disability, or other disability that requires an accommodation in testing, please have this section completed by an appropriate professional (education professional, doctor, psychologist or psychiatrist) to certify that your disabling condition requires the requested test accommodation.

IF YOU AVE EXISTING DOCUMENTATION OF HAVING THE SAME OR SIMILAR ACCOMMODATION PROVIDED TO YOU IN ANOTHER TEST SITUATION, YOU MAY SUBMIT SUCH DOCUMENTATION INSTEAD OF HAVING THIS PORTION OF THE FORM COMPLETED.

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I have known \_\_\_\_\_ since \_\_\_\_\_  
(Test applicant) (Date)

in my capacity as a \_\_\_\_\_.  
(Professional title)

The applicant has discussed with me the nature of the test to be administrated. It is my opinion that because of this applicant's disability, he/she should be accommodated by providing the following: (Check all that apply)

- Large print test       Taped test
- Reader
- Scribe/Amanuensis
- Extended time
  - Time-and-a-half     Double time
  - More than double time (specify) \_\_\_\_\_
- Separate testing area
- Use of computer or other adaptive equipment (please specify)
- Other (please specify)

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Name (Print) \_\_\_\_\_ Title \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Phone \_\_\_\_\_ License # (if applicable) \_\_\_\_\_