

**ADMINISTRATIVE OFFICE OF PENNSYLVANIA COURTS  
INTERPRETER CERTIFICATION PROGRAM**

**DOCUMENTATION OF ACCOMMODATION**

This section must be completed by an appropriate professional (doctor, psychologist, psychiatrist, or education professional) to certify that your disabling condition requires the requested exam accommodation.

If you have 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.

I HAVE KNOWN \_\_\_\_\_ SINCE \_\_\_\_\_  
(APPLICANT NAME) (DATE)

AS A \_\_\_\_\_. I HAVE DIAGNOSED OR EVALUATED  
(PATIENT OR OTHER PROFESSIONAL RELATIONSHIP)

THE APPLICANT MYSELF AND I AM NOT RELYING UPON FACTS RELATED TO ME  
BY THE APPLICANT. MY DIAGNOSIS IS \_\_\_\_\_

\_\_\_\_\_  
(DESCRIBE THE MEDICAL OR OTHER CONDITION)

THE APPLICANT HAS DISCUSSED WITH ME THE NATURE OF THE TEST TO BE ADMINISTERED. IT IS MY PROFESSIONAL OPINION THAT BECAUSE OF THIS APPLICANT'S DISABILITY, HE/SHE SHOULD BE ACCOMMODATED BY PROVIDING THE FOLLOWING: (CHECK ONLY THOSE THAT APPLY)

<input type="checkbox"/>	Large print type	<input type="checkbox"/>	Extra time (how much?)
<input type="checkbox"/>	Separate testing area	<input type="checkbox"/>	An examination reader
<input type="checkbox"/>	Other oral administration (describe)	<input type="checkbox"/>	Other accommodation (describe)

Signature and title of professional _____
Printed name and title _____
Date _____ Telephone Number _____