

ISACA Exam Special Accommodation Request Form

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To qualify for a testing accommodation under the Americans with Disabilities Act (ADA), you must demonstrate that you have a qualifying disability that necessitates the provision of a testing accommodation. A disability is defined by the ADA as a physical or mental impairment that substantially limits one or more major life activities, as compared to most people in the general population. Supporting medical documentation is your responsibility and is prepared and obtained at your expense.

Candidates requesting a special accommodation for an ISACA examination must have this form completed by a health care professional in order for their accommodations request to be processed. This request will be valid for one exam administration.

To request a testing accommodation for a disability, submit this request (both pages) and all supporting documentation to: ISACA via email to SPECIALaccom@isaca.org or via fax +1.847.253.1755. Please note that incomplete forms may cause delays in processing and/or the ability to make the appropriate arrangements for your accommodation by your testing date.

All requests must be received by the examination registration deadline. However, we recommend submitting your requests as far in advance of the deadline as possible. Some requests require substantial investment of time to review if, for example, additional supporting documentation is needed and, once granted, to make the necessary arrangements.

Important scheduling note for CSX exams: DO NOT schedule a CSX exam until you receive written notification that accommodations have been approved by ISACA. Accommodations will NOT be added retroactively to previously scheduled exam appointments and exam fees will NOT be refunded.

Specific to any health information provided to ISACA, ISACA will delete your information and associated documentation within one week of your exam administration. Exam candidate will have the right to be provided a copy of his or her own documentation and to update such; will be provided notice regarding ISACA's use of their documentation; and documentation provided will not be disclosed to law enforcement officials, absent a compulsory legal process, such as a warrant or court order.

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This section to be completed by the exam candidate:

Candidate Information:

ISACA ID: _____

Name: _____

Address: _____

- Exam Testing: CISA CISM CGEIT CRISC
 CSX | Practitioner
 CSX | Specialist Identify and Protect CSX | Specialist Detect
 CSX | Specialist Respond and Recover
 CSX | Expert

Proposed Exam Date: _____

Proposed Site or Country Testing In: _____

Candidate Release:

Dear Health Care Provider,
I am requesting a special accommodation for my ISACA exam. I authorize you, my health care provider, to complete the ISACA Exam Special Accommodation Request Form and to provide such information as you deem relevant for this request.

Candidate Signature: _____ Date: _____

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ISACA ID number: _____

Candidate Name: _____

This section to be completed by a health care professional:

HEALTH CARE PROFESSIONAL DOCUMENTATION OF DISABILITY-RELATED NEEDS

This section is to be completed by a health care professional. The specific testing accommodations needed must be included with this request. This request will be valid for one exam administration.

I have known _____ since _____ in my capacity as a(n)
(Name of Candidate) (Date)

(Professional Title)

The candidate discussed with me the nature of the test being administered. It is my opinion that because of this applicant's disability, I concur that he/she should be accommodated by providing the special arrangements during the exam administration as outlined below.

Specific Testing Accommodations for this candidate: (Please check all that apply.)

- Extended testing time, (please specify): _____
- Large print test.
- Separate testing area
- Special seating, please describe: _____
- Wheelchair accessible testing site
- Food
- Drink
- Other special accommodations (please be specific): _____

Signature – Health Care Professional: _____

Title: _____

Organization: _____

License # (if applicable): _____

Phone Number: _____

Date: _____

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