

General Information

- This form is to be completed by the Special testing coordinator.
- Incomplete and/or unsigned forms will not be processed.
- Faxed or emailed forms will not be accepted.
- Do not register online.

A. Examinee Information (print or type)

Examinee Name (Last, First, Middle Initial) _____ Date of Birth (MM/DD/YY) _____

Examinee Street Address or PO Box (if not available, use school address) _____

City _____ State /Province _____ ZIP /Postal Code _____

Email Address (optional) _____

High School Code (if currently attending) _____

B. Test Coordinator Information (print or type)

Test Coordinator Name (Last, First, Middle Initial) _____ Title _____

School Name (attach explanation if not the examinee's school) _____

Street Address of School (required for shipping materials) _____ PO Box _____

City _____ State/Province _____ ZIP/Postal Code _____

Email Address _____ Phone Number (daytime) _____

C. Previous Approval of the Same Accommodations on the ACT

Has the examinee been approved for accommodations on the ACT and does the current IEP, 504 Plan, or official accommodations plan support providing these accommodations?

- If yes, complete only Sections A–H and M. In the box to the right, write in the test date and ACT Reference Number found on the examinee's approval letter. Then submit this Request.
- If no, complete the entire application and attach required documentation before submitting.

Test Date	ACT Reference Number

D. Test Option, Testing Window, and Deadline

- **Mark only one testing window and test option.**

Note: If a Request is postmarked after the regular deadline but received before the late deadline, it will be processed for the preferred test date **IF** the Late Registration fee is included. For a complete list of deadlines, visit www.actstudent.org.

Testing Window	Regular Deadline	Testing Window	Regular Deadline	Test Option (mark one)
<input type="checkbox"/> September 12–October 4, 2015	August 7	<input type="checkbox"/> February 6–February 28, 2016*	January 8	<input type="checkbox"/> ACT (no writing)
<input type="checkbox"/> October 24–November 15, 2015	September 18	<input type="checkbox"/> April 9–May 1, 2016	March 4	<input type="checkbox"/> ACT with writing
<input type="checkbox"/> December 12, 2015–January 3, 2016	November 6	<input type="checkbox"/> June 11–July 3, 2016	May 6	

**This window is not available outside the United States or Canada.*

E. Diagnosed Disability (check all that apply)

Learning Disability (01)

- (RD) Reading Disorder
- (DW) Writing Disorder/Written Expression
- (DA) Mathematics Disorder
- (SL) Speech/Language Disorder*

Physical/Sensory Disability (02)

- (DF) Hearing Impairment*
- (PH) Motor Impairment _____
(e.g. cerebral palsy, muscular dystrophy)
- (VI) Visual Impairment* _____
(e.g. 20/100 corrected visual acuity)
- (TR) Tourette's Syndrome*
- (EP) Epilepsy or Seizures*

Psychological Disability (03)

- (AD) ADD/ADHD
- (AX) Psychiatric Disorder* _____
(e.g. Mood or Anxiety Disorders)
- (BD) Emotional/Behavioral Disorder
- (AU) Autism Spectrum Disorder
- (AU) Asperger's Disorder/PDD*
- (TB) Traumatic Brain Injury*
- (PD) Other Psychological/Cognitive Disability Including mental or intellectual disability
Full scale IQ is required: _____

Other Disability (07)

- (HB) Confined to the home* _____
- (OD) Other* _____

*Complete documentation is required if the first diagnosis was within the last 3 years and for ALL visual, hearing, psychological, emotional, or physical disorders.

F. Test Format Requested (check at least one)

Alternate formats must be supported by an accommodations plan and documentation. Examinees using reader's script must test individually. Examinees using DVDs may test as a group.

- (01) Regular type (10-point)
- (02) Large type (18-point)
- (03) Braille (printed copy included)
- (07) Reader's script w/regular type
- (08) Reader's script w/large type
- (09) Reader's script w/raised line drawings
- (19) DVDs w/regular type
- (20) DVDs w/large type
- (21) DVDs w/raised line drawings

G. Time Requested (check one)

- Standard time on each test; authorization to test over multiple days.
- Extended time on each test; authorization to test over multiple days.
- Extended time only on writing test (60 minutes)
- Extended time on each test (50% more time); all in one day.
(See National Extended Time on page 2 before checking this box.)

H. Additional Accommodations Requests (e.g. computer, double time, mark answers in the test booklet)

(Full documentation, including specific diagnosis, is required)

I. Current IEP, 504 Plan, or Official Accommodations Plan

- 1. Staple a copy of the most current test accommodations/services pages from the examinee's IEP, 504 Plan, or official accommodations plan to this request. Check the box to indicate the plan you are submitting.
 IEP 504 Plan Official Accommodations Plan Exceptions Statement

The IEP, 504 Plan, or official accommodations plan must state the need for the requested accommodations. The examinee's name and effective dates must also appear on each page.

- 2. Check ALL school years in which an IEP, 504 Plan, or official accommodations plan has been in place for the examinee.
 Grade 12 Grade 11 Grade 10 Grade 9 Grade 8 Before grade 8
- 3. Do any of the following apply?
 - The plan has been in place *less than 3 academic years*.
 - The section labeled **Diagnosed Disability** includes an asterisk indicating full documentation is required.
 - Any **Additional Requests** are checked.

If yes, *also* staple a copy of full documentation, including specific diagnosis to the application.

J. Current Time Accommodations at School

Check YES or NO. If NO, see "Exceptions Statement and Complete Documentation Required" below.

YES NO Does your school officially **permit** this examinee extended time for tests (classroom and standardized) **as a result of this diagnosis and supporting documentation?**

EXCEPTIONS STATEMENT AND DOCUMENTATION REQUIRED. If the requested accommodations are officially permitted or used, by this examinee due to the diagnosis, attach a signed statement on school letterhead from a qualified professional (on staff at the school or school district) who has reviewed the examinee's file to: 1) state under what circumstances accommodations would be permitted for this examinee in the school and the basis for providing that accommodation (include **complete documentation**—see "Guidelines for Documentation" on page 3); 2) explain why accommodations are not currently provided; 3) explain why you believe accommodations should be allowed for the ACT; 4) describe any assistance provided for this examinee outside of school, if known. Exceptions require additional time for review; apply as early as possible.

K. School Official's Signature and Contact Information

I certify that I have read and understand the Policies for ACT Special Testing and that the information on this form and in the attached accommodations plan and documentation is submitted in accordance with the Policies for ACT Special Testing. I further certify that the information provided is accurate to the best of my knowledge, and reflects the test accommodations currently provided in school to the examinee identified on this form.

School Official's Signature (may not be a relative of examinee)

Fax Number (include area code)

Print Official's Name, Title, and School

Email

Phone number (include area code)

L. Examinee Signature

I certify that I am the person whose information is submitted in accordance with the Policies for ACT Special Testing on this form, and that the information provided is accurate to the best of my knowledge.

I understand that by signing below, I consent to the ACT Privacy Policy (www.act.org/privacy.html), which is incorporated into these Policies for ACT Special Testing by reference, including consent to the collection of personally identifying information and its subsequent use and disclosure.

Without limiting the above statement, I specifically authorize the release to ACT of diagnostic information by school officials, physicians, or others having such information, and full documentation, if requested. I understand that any documentation provided to ACT will remain with the application and will not become part of my examinee score record.

International Examinees: *By signing below, I am also providing my consent to ACT to transfer my personally identifying information to the United States to ACT or a third party service provider for processing, where it will be subject to use and disclosure under the laws of the United States. I acknowledge and agree that it may also be accessible to law enforcement and national security authorities in the United States.*

Examinee's Signature

(Parent or guardian must also sign if examinee is under 18.)

Date

M. Test Coordinator Signature

*I certify that I personally meet all of the requirements for the Special Testing Coordinator specified in the ACT Policies for ACT Special Testing and that I or a member of my staff who also meets the same requirements will administer the tests in accordance with the ACT Administration Manual sent with the test materials. I will ensure that the test materials are kept secure and confidential, **used only for the examinee identified on this form**, and returned to ACT **immediately** after testing.*

I understand that by agreeing to be a Special Testing coordinator, I consent to the ACT Privacy Policy (www.act.org/privacy.html), which is incorporated into these Policies for ACT Special Testing by reference, including consent to the collection of my personally identifying information and its subsequent use and disclosure.

International Test Coordinators: *By my signature, I am also providing my consent to ACT to transfer my personally identifying information to the United States to ACT or a third party service provider for processing, where it will be subject to use and disclosure under the laws of the United States. I acknowledge and agree that it may also be accessible to law enforcement and national security authorities in the United States.*

Test Coordinator Signature (must match the name in Section B)

Date

N. Return of Request Form

Detach and mail this completed form, all required supporting documentation, and fee payment to:

ACT Special Testing, 301 ACT Drive, PO Box 4028, Iowa City, IA 52243-4028