Certified Healthcare Internal Audit Professional™

Special Accommodations Request Form

Part I. Applicant Information

To be completed by Applicant/Candidate

If you require special accommodations at the PSI Testing Center, complete this form and provide the documentation of disability-related needs on the next page. Upload the completed form in the Certification Management System when completing your CHIAP™ application. If a condition arises after you have already completed your online application, submit the form to AHIA at certification@ahia.org. Forms must be submitted 45 days prior to the exam date. The information you provide and any documentation regarding your disability and your need for accommodation in testing will be treated with strict confidentiality.

Name:

Address:

Telephone: **Cell Phone:**

Email Address:

Special Accommodations:

I request special accommodations for the Certified Healthcare Internal Audit Professional™ examination.

Please provide (check all that apply):

- Extra breaks – Stretching/ Drinks
- Extended testing time (time and one half or double time)
- Job Access with Speech (JAWS)
- Reader
- Screen Magnifier/ Enlarged Font
- Scribe
- Separate Room
- Sign Language Interpreter (to facilitate communication with test center personnel only)
- Wheelchair Access
- Please specify below if other special accommodations are needed.

Comments:

PLEASE READ AND SIGN :

I give my permission for my diagnosing professional to discuss my records and history as they relate to the requested accommodations with AHIA and PSI.

______________________________ ______________________________

Signature Date

Certified Healthcare Internal Audit Professional™

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Part II. Documentation of Disability-Related Needs

To be completed by Appropriate Professional

This section must be completed and signed by an appropriate professional (education professional, physician, psychologist, or psychiatrist) to ensure that PSI is able to provide the required accommodations.

I have known **since** **in my capacity as a**

Applicant/Candidate Name **Date**

My Professional Title .

The candidate discussed with me the nature of the test to be 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 in Part I, Applicant/ Candidate Information, of this request form.

Description of Disability:

Complete, sign and return this form to the applicant/ candidate.

By signing this form, I certify the information presented is accurate and complete.

Signature: ____**Title:**

Printed Name:

Name of Practice, Medical Group or Organization:

Address:

Telephone Number: **Email Address:**

Date: ____ **License # (if applicable):** ______________________________________