AMERICAN BOARD OF CRIMINALISTICS
MEDICAL DOCUMENATION OF DISABILITY OR MEDICAL CONDITION

THIS STATEMENT MUST BE COMPLETED BY A LICENSED MEDICAL PROFESSIONAL

Dear Licensed Medical Professional:

The American Board of Criminalistics (ABC, the Board) requires a licensed physician or other licensed medical professional in the field related to the applicant's disability to complete this form. The Board provides testing accommodations for their exams to persons with disabilities. The Board requires current medical or learning disability documentation (within the last two years). After you complete this form, please return to your patient (applicant). It must be submitted by the applicant along with the completed Application for Testing Accommodations and any other required documentation regarding their particular disability.

Records, accompanying application and requisite forms must be submitted by the Applicant (Patient) to the address below:

American Board of Criminalistics Registrar
P.O. Box 1358
Palmetto, FL 34221

This information may be forwarded to a licensed medical professional for the purpose of evaluating the applicant's request.

Please TYPE.

Patient Name: _____ Date of Birth: _____

Licensed Medical Professional

Name: _____
Occupation,
Title & Specialty: _____
Address: _____
Telephone Number: _____

Please describe your qualifications and experience to diagnose and / or verify the applicant's disability and to recommend an accommodation:

What is the specific diagnosis of the condition or impairment for which the applicant requests test accommodations? Please attach a copy of assessment results.

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Briefly describe the nature of the impairment:

Briefly describe how the impairment affects the applicant in a test situation:

Current treatment consists of the following:

If applicable, is patient compliant with prescribed medication? ☐ Yes ☐ No
Last date of treatment / date of consultation with patient:
Is this a permanent condition? ☐ Yes ☐ No
If no, when is the condition likely to abate?
Is the patient following the prescribed course of treatment? ☐ Yes ☐ No
If no, please explain:

The ABC Examination is comprised of all multiple choice questions and is administered for a three hour period from start to finish. In what way does the prescribed course of treatment improve the patient's ability to read, write, concentrate or function in a test setting over extended periods of time?

Does the patient's condition / disability / impairment prevent the applicant from taking the examination under standard testing conditions?

☐ No ☐ Yes If yes, how?

Given the patient's condition / disability / impairment and your diagnosis, what testing accommodations do you recommend? (check all that apply)

☐ Assistive device provided by examinee; describe specifically:
(i.e. magnifying glass, brace, heating pad, etc.)
☐ Reader for visually impaired candidates (May require separate room as well)
☐ Necessary medical breaks (May NOT be requested along with additional testing time).
☐ Additional testing time: ☐ time and one half (total of 4.5 hours)
☐ Double time (total of 6.0 hours)
MAXIMUM ALLOWABLE TIME LIMIT
☐ Other (must describe specifically):

Additional Test Time Recommended by Physician or Medical Professional

If you are recommending that the patient bring special equipment or personal items into test room (e.g., medications, special chair, heating pad, etc.), please describe:

In what way will the recommended accommodation assist the applicant with their disability?

I certify that all the information on this form is true and correct to the best of my knowledge and believe.

I have attached copies of all relevant records requested by this form along with this form.

I understand that the patient's request for testing accommodation will not be processed without these records.

I understand that this statement and attached documentation may be reviewed by a licensed medical professional retained by the American Board of Criminalistics to assist the Board in determining what testing accommodations will be granted, if any.

_____ _____

Signature of Licensed Medical Professional Date

_____

Printed name and Title with Specialty, if applicable