

NLN TESTING
Request for Special Testing Accommodations



School Administrators and Health Care Professionals:

This form must be completed and submitted to the National League for Nursing (NLN) for all special testing accommodations requests. To process your information efficiently, the NLN must receive all information at least two weeks in advance of your planned test date.

Please note: The information provided regarding an examinee's disability and need for special testing accommodations will be considered strictly confidential and will not be shared with any outside source without the examinee's express written consent.

Examinee's Information

Last Name: _____ First Name: _____

Phone Number: _____ Email: _____

Last 4 digits of SSN: _____ and / or Date of Birth: _____

School Information

School Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

School Contact Information:

Name of School Administrator: _____

Title: _____ Daytime Phone Number: _____ Fax Number: _____

Email: _____

Continue to next page

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Special Accommodations:

Please provide (check all that apply)

- Special seating or other physical accommodations
- Calculator
- Reader
- Extended testing time (normally 1.5 additional hours): _____
- Separate testing area
- Other (please specify) _____

Specify Test Title: _____

Documentation from health care professional(s) related to this request should NOT be attached.

Signed: _____

(Please indicate: School Administrator [SA] or Health Care Professional [HCP])

Date: _____

Return this form to:

NLN
Attn: Leanne Furby, MEd
1840 Innovation Drive, Suite 106, Carbondale, IL 62903
Fax: 618-453-3333

For Office Use Only:

Special testing accommodations are: _____ Granted _____ Denied

Signed: _____, Leanne Furby, MEd