CAIA Association
11 Amity Street, Amherst MA 01102
www.caia.org
accomodations@caia.org

PROFESSIONAL EVALUATION FORM
TO SUPPORT TESTING ACCOMMODATION REQUEST(S)

This form consists of a

1. **Personal Statement** to be completed by the candidate/patient **and a**
2. **Medical Professional Questionnaire**, to be completed by a qualified medical professional.

Both documents must be submitted at the same time at least 6 weeks prior to the exam window.

1. Personal Statement & Authorization Section

To be completed by Candidate requesting testing accommodation

Candidate's Name: _____
Legal first and Legal last name

Phone number: _____ **E-mail:** _____

CAIA Exam Level: _____ **CAIA ACCOUNT ID #:** _____

I authorize _____ to complete the below documentation relating to my physical and/or mental impairment(s) and request for testing accommodation(s). I agree that only documentation completed/provided by a certified or licensed professional will be accepted. I understand it is my responsibility to have the below portion completed by a certified or licensed medical professional and upload into the Accommodations Request Form during completion of that form.

_____ _____
Candidate Signature **Date**

About the CAIA Exam: There are two levels of the CAIA exam -- Level I and Level II. All levels of the CAIA exam are computer-based. The format of the Level I exam is all multiple choice. The Level II exam is a combination of 70 percent multiple choice and 30 percent constructed response (essay) item sets. The item set format asks candidates to read through vignettes (i.e., story lines or short case studies) before answering several questions related to the passages. The essay format requires candidates to type one or several paragraphs in response to each question. Each level is approximately a 5-hour experience. Sections one and two are 120 minutes each. There is an optional 30-minute break between each of these sections. There are no other "scheduled" breaks.

- Testing accommodations for CAIA exams are granted in compliance with the law. The law applies to a candidate if the candidate's physical or mental impairment substantially limits his or her ability to sit for the exam as compared to the general population.
- CAIAA only evaluates requests for accommodation for a candidate's current exam level and active registration.
- Test centers serve several testing programs, and it is expected that multiple people will be sitting for exams in the testing room at the same time.

The following professionals are deemed appropriate and qualified to complete this form and provide a diagnosis of:

- **Attention Deficit/Hyperactivity Disorder (AD/HD)**: licensed Clinical Psychologist, licensed Neuropsychologist, and licensed Psychiatrist.
- **Learning Disabilities (LD)**: licensed Clinical Psychologist, licensed Neuropsychologist, licensed Educational or School Psychologist, Educational Diagnostician, Learning Disabilities Specialist, or Educational Therapist.
- **Mental Disabilities**: licensed Clinical Psychologist, licensed Psychiatrist, or other licensed Mental Health Professional.
- **Physical Disabilities**: licensed Physician or licensed Professional.

In addition to completing this form, a separate evaluation that complies with the guidelines below should be submitted:

- ✓ Be up-to-date and comprehensive; as a guideline, CAIAA suggests that the most recent evaluation is less than three years old
- ✓ Meet full, standard criteria for determination with an explanation of differential diagnosis, an evaluation of current impact, and a clinical summary supported by a rationale
- ✓ With the exception of physical disabilities (including visual and hearing impairments), all evaluations must have a diagnosis that conforms with the Diagnostic and Statistical Manual of Mental Disorders (DSM-5)
- ✓ Provide evidence that this diagnosis does not rely solely on self-report in establishing developmental history, current symptoms, and evidence of clinically significant impairment
- ✓ Explain past and current treatments for this condition and the effects of these treatments in ameliorating symptoms
- ✓ Provide objective evidence of a material restriction in the area for which an accommodation is requested

2. Medical Professional Questionnaire

To be completed by a qualified professional. Type or print legibly and in English

Candidate Name: _____

The individual listed above has requested accommodation(s) for his/her physical or mental impairment(s). To help us evaluate the requested accommodations, we ask that you please provide the following information:

1. **Diagnosis**
   - Physical impairment: _____
   - Mental impairment DSM-5 diagnosis: _____

   Date the patient was first diagnosed: _____ MM/DD/YYYY
   Date of your most recent diagnosis of the patient's disability: _____ MM/DD/YYYY

   ☑ **Is the disability a permanent condition**? ○ Yes ○ No
   If no, when is the condition likely to abate? _____ MM/DD/YYYY

2. **Evaluation (Please submit a separate evaluation and other relevant documentation as described on page 1)**
   ☑ **Is the patient significantly impaired in his or her ability to read, write, and/or concentrate for extended periods of time? If so, explain:**

➔ Continued on the next page

☑ **Describe and attach results of any objective testing you performed on the patient that suggests the patient is unable to perform an activity an average person in the general population can perform:**

☑ **Describe and attach results of any objective testing you performed on the patient that suggests the patient is unable to perform an activity an average person in the general population can perform:**

☑ **Were alternate explanations for presenting complaints ruled out via a thorough differential diagnosis? If so, please explain:**

☑ **Do(es) the treatment(s) that the patient has received in the past and/or is currently receiving and the effect of treatment on the condition reduce the patient's impairment? If yes, please describe.**

☑ **Recommendation**
Indicate accommodation(s) you recommend based on patient's disability and your diagnosis
Note: Your rationale should link the recommended accommodation(s) to the patient's areas of documented impairment.
If recommending additional time, specify amount of time per session, additional % per session.

Acknowledgement

Medical Professional Name: _____

Title: _____ **Agency/Hospital:** _____

Address: _____**City:** _____

Country: _____**Zip:** _____ **Phone:** _____

I certify that all the information on this form is true and correct to the best of my knowledge and belief. I understand that this information may be reviewed by a qualified professional retained by CAIAA to assist in determining testing accommodations. I understand that completing this request form alone is not sufficient evidence to support a request for testing accommodation.

_____ _____
Medical Professional Signature **Date**