Testing and Certification Accommodations Request

SHRM is fully committed to ensuring access to the SHRM-CP and SHRM-SCP certification examinations, as well as providing modifications to our certification and recertification policies, for all individuals with disabilities covered by the Americans with Disabilities Act (or the Canadian/ Australian equivalent). SHRM provides reasonable accommodations to individuals with documented disabilities who demonstrate a need
for special accommodations. Requests for special accommodations are inherently individualized and considered on a case-by-case basis. Therefore, no single type of accommodation will be appropriate for all individuals with disabilities.

To request special accommodations, the individual seeking an accommodation must complete this form and have a qualified licensed professional complete the Professional Evaluation. The professional must be an individual qualified to assess, diagnose and treat the stated disability. Any information and documentation provided regarding the disability and the need for accommodation in testing will be kept strictly confidential and will be shared only to the extent necessary with our testing vendor. Do not provide any medical records to SHRM. SHRM does not require, nor does it wish to receive, medical records to assess your request.

Section I. Applicant/Candidate Information

FIRST NAME | MIDDLE NAME | LAST NAME

PRIMARY MAILING ADDRESS

CITY | STATE/PROVINCE | ZIP/POSTAL CODE | COUNTRY

PHONE NUMBER | E-MAIL

Section II. Testing Accommodations Request (if applicable)

EXAM WINDOW

Exam:

☐ SHRM-CP
☐ SHRM-SCP

One of the requirements when requesting testing accommodations from SHRM is to provide a history of previously granted testing accommodations for similar testing experiences.

Have you ever been granted testing accommodations?

☐ YES
☐ NO

If YES, please document at least one instance where testing accommodations for a similar testing experience were granted.

YEAR OF ACCOMMODATION	TYPE OF ACCOMMODATION	NAME OF INSTITUTE/ORGANIZATION THAT PROVIDED ACCOMMODATION

Testing and Certification Accommodations Request

Section III. Policy Accommodations Request (if applicable)

In the table below, please provide the applicable policy (e.g., cancellation, refund or transfer), as well as the specific accommodation (i.e., policy modification) requested.

POLICY	TYPE OF ACCOMMODATION/MODIFICATION

By submitting this document, I consent to the transfer, collection, processing and use of my information by the Society for Human Resource Management (SHRM), an entity located in the United States, in accordance with the SHRM Privacy Policy, and solely for the purpose of evaluating and providing the above-requested accommodation(s). Further, I understand that SHRM may disclose and transfer such information to the testing center, which may be located outside the United States, only as reasonably necessary to provide the above-requested accommodation(s). Such information will be treated with strict confidence, in accordance with the SHRM Privacy Policy and the SHRM Certification Handbook.

PRINTED NAME

SIGNATURE DATE

Testing and Certification Accommodations Request

Section IV: Professional Evaluation (to be completed by a qualified health care professional)

DOCUMENTATION OF DISABILITY-RELATED NEEDS BY QUALIFIED PROFESSIONAL*
A qualified health care professional (i.e., physician, psychologist, psychiatrist) must complete this section to ensure that SHRM is able to provide the appropriate accommodations for taking a multiple choice exam, or for providing the appropriate certification policy modifications.

NAME OF PROFESSIONAL | TITLE | OCCUPATION

PRIMARY MAILING ADDRESS | SUITE/UNIT/APT #

CITY | STATE/PROVINCE | ZIP/POSTAL CODE | COUNTRY

PHONE | E-MAIL

***MUST be licensed/certified to assess, diagnose and treat the stated disability.**

The following information must be included in the description below: (1) **the length of time you have treated the candidate and whether treatment has ended or is ongoing,** (2) **the nature of the disability as it relates to the candidate's ability to sit for the exam or comply with the applicable policy,** (3) **a description of how the disability has affected or will affect the candidate's ability to sit for the exam or comply with the applicable policy,** (4) **how long you expect the candidate's limitations to continue, such that they will continue to require the testing accommodation or modification of the applicable policy, and** (5) **the specific test accommodations or policy modifications requested.**

DESCRIPTION OF DISABILITY

ACCOMMODATION(S) REQUESTED

DATE OF DIAGNOSIS/ONSET

LICENSE/CERTIFICATION NUMBER | EXPIRATION DATE

I have evaluated _____ on ____ /____ /____ in my capacity as a
CANDIDATE'S NAME

The candidate discussed with me that a multiple choice exam was, or will be, administered. It is my professional opinion that because of this applicant's disability, described above, he or she should be provided with the testing accommodations and/or policy modifications indicated.

SIGNATURE | DATE