

## REQUEST FOR DISABILITY ACCOMMODATIONS 2009

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### DEADLINE FOR SUBMISSION: AUGUST 31, 2009

The Global Association of Risk Professionals (GARP) provides reasonable and appropriate testing accommodations for the Financial Risk Manager (FRM®) Examination for those who are disabled. An "accommodation" is any modification in the standard administration of the FRM Examination.

A candidate requesting accommodations must document the existence of a physical or mental impairment which significantly limits the candidate's ability to perform a major life function; the current impact of the impairment and how it affects the candidate's ability to take the FRM under standard conditions; and a rationale and objective basis for the requested accommodation.

#### *To request an accommodation, you must:*

- Enroll and register for the FRM examination, no later than August 31, 2009.
- Last day to register as an ADA candidate: August 31, 2009.
- Identify which test site you have selected to sit for the exam. \_\_\_\_\_
- Please indicate which FRM Exam you have enrolled and registered for:     FRM Exam – Full     FRM Exam – Level I
- Complete and submit the *Request for Testing Accommodation Form*.
- Complete Part I of the appropriate *Medical Verification Form* and have a qualified professional who is familiar with the impact of your disability and of your ability to perform on the FRM or other similar timed standardized test complete Part II of the same form. Submit the completed form, along with supporting documentation.
- Make certain that GARP receives these documents in one package, no later than August 31, 2009. GARP will not review your Request For Accommodation until both forms are completed and received.
- You will receive an email confirming your request. If GARP cannot grant your request for accommodations, you will be notified no later than October 1, 2009.
- Send your request and all supporting documentation to the attention of the FRM Administrator via fax +1.201.222.5022, or mail to:  
GARP  
Attn: FRM Administrator  
111 Town Square Place, Suite 1215  
Jersey City, NJ 07310

# REQUEST FOR DISABILITY ACCOMMODATIONS 2009

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## REQUEST FOR TESTING ACCOMMODATION FORM (To be completed by candidate)

GARP must receive this completed form, along with the *Medical Verification Form* and all supporting documentation, no later than August 31, 2009. Please type or print legibly. (You may type directly on this form).

### I. CANDIDATE INFORMATION

Name: \_\_\_\_\_  
*Last (Surname)* *First (Given)* *Middle Name or Initial*

GARP ID Number: \_\_\_\_\_

Which FRM Exam you have registered for:  FRM Exam – Full  FRM Exam – Level I

What site have you selected to sit for the FRM Exam: \_\_\_\_\_

Have you previously sat for the FRM examination?  Yes  No

What site did you use, when you previously sat for the FRM Exam: \_\_\_\_\_

If yes, did you request testing accommodations to take the examination?  Yes  No

If yes, briefly describe the accommodations granted to you, if any.

\_\_\_\_\_

\_\_\_\_\_

### II. NATURE OF DISABILITY (check all that apply)

- Physical Disability
- Visual Disability
- Hearing Disability
- Cognitive or Learning Disability
- Psychological Disability
- AD/HD
- Other \_\_\_\_\_

### III. REQUESTED ACCOMMODATIONS (Note: Accommodation(s) must be appropriate to the disability and supported by documentation.)

- Scribe
- Wheelchair access
- Semi-private room/distraction-reduced environment
- Additional time
- Large print examination (Please indicate font size)
- Consumption of food and/or drink
- Assistance for visually impaired
- Other \_\_\_\_\_

**REQUEST FOR DISABILITY ACCOMMODATIONS 2009**

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Please describe in detail the type of accommodations requested:

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If requesting special equipment or personal items in the testing room (e.g. medications, special chair, special lighting), please describe:

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If you are requesting additional time, indicate the amount of time needed per session as supported by documentation.

Session: Additional Time Requested:

FRM Exam – Full (Each session is 2.5 hours)

Morning \_\_\_\_\_  Afternoon \_\_\_\_\_

FRM Exam – Level I (Each session is 2.0 hours)

Morning \_\_\_\_\_  Afternoon \_\_\_\_\_

**IV. CANDIDATE ACKNOWLEDGEMENT**

I declare that the person completing the written report is a bona fide qualified professional who has diagnosed and/or treated me for the disability for which I am seeking an accommodation.

I agree to notify GARP of any material changes in my condition. I understand that any false or misleading information I give in connection with this test may subject me to discipline in accordance with the GARP Code of Conduct, which could include the suspension or termination of my candidacy or right to use the FRM designation.

I understand that documentation submitted in support of this request may be referred to one or more qualified professionals retained to assist GARP in evaluating and/or implementing requests for accommodation. I further understand that documentation submitted must be current or updated within the last two years. If documentation is determined by GARP to be insufficient or not current, I understand that I may be required to submit additional or more current information.

I understand that I may not be granted an accommodation by GARP.

I declare that all information I have supplied in connection with this examination is truthful and complete.

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*Candidate Signature*

*Date*

**MEDICAL DECLARATION IN SUPPORT OF REQUEST FOR DISABILITY ACCOMMODATION**

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GARP must receive this completed form, along with all supporting documentation, no later than August 31, 2009.

**Part I – To be completed by candidate**

**Part II – To be completed by physician or licensed professional**

Candidates requesting accommodation based on disability must provide an evaluation. The evaluation must:

- Be conducted by a qualified professional who is familiar with the impact of the candidate’s disability on his or her ability to perform on the FRM exam or other similar timed standardized test;
- Have been completed or updated within the last two years;
- Provide an explanation of differential diagnosis and an evaluation of current impact of the candidate’s disability on his or her ability to perform on the FRM exam or other similar timed standardized test;
- Provide data-based evidence of significant impairment in the area for which an accommodation is requested;
- Provide evidence that this diagnosis does not rely solely on self-report in establishing developmental history, current symptoms, and evidence of clinically significant impairment.

It is important to provide professional documentation from all evaluations. Please attach all relevant documentation that documents a history of significant impairment.

**This form must be submitted along with the Request for Testing Accommodation Form.**

**PRIVACY OF MEDICAL INFORMATION**

GARP will not share your medical information except as necessary for evaluating a request for accommodations or implementing a granted accommodation. Only authorized GARP staff and consultants involved in evaluating or implementing requests for accommodations may access information regarding disability accommodations requests on a need to know basis. Please be sure to address all inquiries to the FRM Administrator at the contact information located on page 1.

**PART I** (To be completed by candidate) Type Directly on this Form or Print Legibly.

Name: \_\_\_\_\_  
*Last (Surname) First (Given) Middle Name or Initial*

Provide a description of your disability and the extent of its effect on your daily life activities. Use separate sheets if necessary.

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Please describe how the condition affects your ability to take the FRM examination, and explain why you need the accommodation(s) requested. Use separate sheets if necessary.

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**MEDICAL DECLARATION IN SUPPORT OF REQUEST FOR DISABILITY ACCOMMODATION**

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**PAST DISABILITY ACCOMMODATIONS RECEIVED**

Did you receive formal disability accommodations in high school?  Yes  No

Please describe the disability accommodations you received (include any other disability accommodations/modifications received):

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Did you receive formal disability accommodations in college?  Yes  No

Please describe the disability accommodations you received (include any other disability accommodations/modifications received):

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If you answered "yes" to either of the above questions, please attach any records or other documentation concerning the diagnosis and the disability accommodations granted. Include past professional evaluations and/or educational records.

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Have you ever taken the SATs, ACTs, GREs, CFA or other Professional/entrance-type examinations?  Yes  No

If yes, please provide a copy of all disability accommodations granted.

Have you ever requested disability accommodation for the SATs, ACTs, GREs, CFA or other Professional/entrance-type examinations?  Yes  No

If no, please explain. If yes, please indicate whether your request was granted and specify the accommodations granted:

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Has the documentation that you are submitting been completed or updated in the last two years?  Yes  No

*Note: Two years is defined as two years from December 31 of the year the documentation has been completed or updated.*

*For example, documentation completed or updated any time during 2007 would be valid through December 31, 2009.*

I certify that all information on this form is true and correct.

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Candidate Signature

Date

**MEDICAL DECLARATION IN SUPPORT OF REQUEST FOR DISABILITY ACCOMMODATION**

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**PART II** (To be completed by a Physician or Qualified/Licensed Professional)

This form must be completed by a qualified/licensed medical evaluator who is familiar with the candidate's condition and its impact on the candidate's ability to perform on the FRM Examination or other similar timed standardized test. Please reference specific tests, clinical observations, and other objective data and attach relevant documentation.

Type directly on this form or print legibly.

Name of Physician or Licensed Professional: \_\_\_\_\_

Title: \_\_\_\_\_

**DIAGNOSIS**

Provide diagnosis:

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Date the candidate was first diagnosed: \_\_\_\_\_ mm/dd/year

Date of your most recent diagnosis of the candidate's disability: \_\_\_\_\_ mm/dd/year

**EVALUATION**

How does the condition or disability affect the candidate's ability to perform on the FRM?

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**MEDICAL DECLARATION IN SUPPORT OF REQUEST FOR DISABILITY ACCOMMODATION**

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Describe any objective testing you performed on the candidate that would suggest a need for accommodation:

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As a result of my examination and treatment of the candidate, I have made the following findings and conclusions:

**RECOMMENDATION**

Please describe the testing accommodation(s) you recommend:

- Scribe
- Wheelchair access
- Semi-private room/distraction-reduced environment
- Additional time as noted on page 3: \_\_\_\_\_
- Large print examination  
Please indicate font size: \_\_\_\_\_
- Consumption of food and/or drink
- Assistance for visually impaired
- Other \_\_\_\_\_

Please explain your rationale for the requested accommodation:

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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 GARP to assist in evaluating or implementing requests for testing accommodations.

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*Candidate Signature* *Date*

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*License/Certification Number*