Disability Support Services California State University San Marcos 333 S. Twin Oaks Valley Road San Marcos, CA 92096-0001
Tel: 760.750.4906 **Fax:** 760.750.3445 jsegoria@csusm.edu www.csusm.edu/dss/

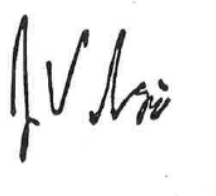
Dear Physician or Appropriate Professional:

Your client/patient has requested special testing accommodations through our Disability Support Services office for the Calculus Placement Exam. Special testing accommodations are available to students who have a qualifying disability which requires a modification to the standard testing conditions.

In an effort to provide your client/patient with special testing accommodations for the Calculus Placement Exam, it is necessary to have written documentation verifying the existence of a disability. In addition to a current diagnosis, specific information is required on how the disability impacts test taking under standard conditions (e.g., slowed cognitive processing, impaired writing).

Please keep in mind the attached Special Testing Verification Form is only being used to substantiate the need for reasonable testing accommodations at CSU San Marcos for the Calculus Placement Exam. Your cooperation in assisting us in providing fair and equitable assistance is appreciated. Should you have any questions, I can be reached at (760) 750-4905.

Sincerely,



John Segoria
Director of Disability Support Services

DISABILITY SUPPORT SERVICES
CALCULUS PLACEMENT EXAM
DISABILITY VERIFICATION

TO BE COMPLETED BY THE CERTIFYING PROFESSIONAL

NAME: _____ PHONE NUMBER: (_____) - _____ - _____

PROFESSIONAL TITLE: _____ LICENSE NUMBER (if applicable): _____

MAILING ADDRESS: _____
STREET

_____ _____ _____
CITY STATE ZIP

PLEASE DESCRIBE THE NATURE OF YOUR CLIENT/PATIENT'S DISABILITY AND HOW IT IMPACTS THEIR TEST-TAKING ABILITY:

_____

_____

* If your client is learning disabled, please include a copy of the Learning Disability Assessment and a cover letter explaining your findings.

BASED ON WHAT YOU KNOW ABOUT YOUR CLIENT'S DISABILITY, WHAT TYPE(S) OF TESTING ACCOMMODATIONS WILL HE/SHE REQUIRE? (Check all that apply)

EXTENDED TIME: ☐ REGULAR TIME | ☐ TIME AND A HALF (X 1.5) | ☐ DOUBLE TIME (X 2) | ☐ TRIPLE TIME (X 3)

☐ ALTERNATE TEST ROOM | ☐ BRAILLE | ☐ READER | ☐ SCRIBE | ☐ ENLARGED PRINT | ☐ COMPUTER ASSISTED

SIGN LANGUAGE INTERPRETER (if selected, please select one of the following below):

☐ SIGNED EXACT ENGLISH | ☐ AMERICAN SIGN LANGUAGE (ASL)

☐ OTHER (if selected, please list other accommodations below):

_____

_____

_____ _____
SIGNATURE OF CERTIFYING PROFESSIONAL DATE