Provider Application for Special Testing Accommodations

Note: Part I – Must be filled out by the candidate/patient
Part II – Must be filled out by health care provider

PART I:

I, [*Enter Candidate Name*] _____, hereby authorize and request my health care provider [*Enter Name*] _____, to release information, requested by the Building Performance Institute, Inc., (BPI), related to my disability and need for special accommodations in order to sit for an examination offered by BPI.

PART II:

Dear Health Care Provider:

The candidate/patient identified above is requesting special accommodations to sit for an examination offered by Building Performance Institute, Inc. BPI's accommodation policy requires candidates requesting special testing accommodations to submit current documentation of the disability from an individual qualified to assess the disability. Would you please submit your evaluation, on your company letterhead, and complete the information below.

Your clinical evaluation should include the following information [cannot be more than three (3) years old]:

1. The month, day and year the candidate/patient first consulted you.
2. The month, day and year the candidate/patient was last seen by you.
3. The diagnosis of the candidate/patient's disability (including the DSM-IV classification for any diagnosis of a learning disability).
4. The length of time in which the condition has existed.

Health Care Provider Information:			
Name:			
Title and Occupation:			
License Number:		State:	Exp. Date:
Employer Name:			
Address:			
City:		State:	Zip:
Phone:			

Are you licensed or certified in an area that allows you to diagnose the disability? **Yes** ☐ **No** ☐

Disability:

Based on your evaluation, what testing accommodations do you recommend for the candidate/patient?

Provider Declaration:
I hereby certify that the above information is true and is given pursuant to the authorization, by my patient, to release information. Under penalty of perjury, I declare that forgoing statements and accompanying documents are true. I hereby certify that I personally completed this portion and may be asked to verify the information at any time.

Physician Name (Printed) _____

Physician Signature _____ **Date** _____

License Number _____ **State** _____ **Exp. Date**_____

Candidate Declaration:
I certify that all information in this application and the accompanying documentation is true and correct. I understand that false information may be cause for denial or revocation of the BPI Certification.

Candidate Name (Printed) _____

Candidate Signature _____ **Date** _____

Submit the information, listed below, to the address that follows:

- Candidate Application for Special Testing Accommodations
- Provider Application for Special Testing Accommodations (this form)
- Clinical evaluation on official letterhead (letter or detailed report)

Mail:	Building Performance Institute, Inc. c/o Testing Accommodations 107 Hermes Road, Suite 210 Malta, New York 12020
Fax:	518-899-1622
Email:	certification@bpi.org