# Health Care Provider Form for Exam Accommodations

The Microsoft Certification Program accepts various types of documentation to support exam accommodation requests. This form is **one** such way to provide that documentation. If you choose to use this form, it must be submitted **at least 20 days** before your preferred exam date.

Your accommodation request will be reviewed by Pearson VUE. This team of accommodation professionals evaluates accommodation requests on a case-by-case basis and will work with you to determine the accommodation that best meets your needs.

***Microsoft employees:*** *Please note that this process is separate from the Workplace Accommodations process. An accommodation granted through this process is not communicated to the Workplace Accommodations Team and should not be construed that an accommodation would be granted through that separate process.*

**Learner to complete the following section:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| NAME (Last, First, MI) | | EMAIL | | |
| HOME ADDRESS (MAILING) | STREET | | | | |
|  | CITY | | STATE | ZIP |
|  | HOME PHONE NO  ( ) | | WORK PHONE NO  ( ) | | |

I request and authorize my health care provider to release health care information and records to Pearson VUE and its designated agents, including external accommodation specialists,to enable Pearson VUE to determine whether and how my medical condition impacts my ability to take an exam or participate in a training event and/or whether any accommodations are required. I understand that law may require that this authorization expire 90 days after I sign it, but I agree to extend that time period if and as needed for the above purposes.

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Learner Signature Date

**If you are under 18, a parent or guardian must also sign.**

Parent/Guardian’s Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health care provider to complete the following section:**

Please answer, fully and completely, all applicable questions. If you cannot provide a definitive answer, your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| HEALTH CARE PROVIDER’S NAME | | | PROFESSIONAL SPECIALTY/TRAINING | |
| STREET ADDRESS | | | | |
| CITY/STATE | ZIP | PHONE NUMBER | | FAX NUMBER /EMAIL ADDRESS |

In order for your patient to be considered for reasonable accommodations, PLEASE ANSWER ALL QUESTIONS COMPLETELY:

Exam Accommodation Request

1. Does your patient require an accommodation in order to take a timed, computer based exam that contains a variety of item types, including but not limited to multiple choice, drag and drop, build list and re-order, and labs that require performing tasks in one of Microsoft’s technologies (e.g., Azure, Microsoft 365, Dynamics 365)? Learn more about our question types [here](https://docs.microsoft.com/en-us/learn/certifications/exam-duration-question-types#question-types-on-exams).

Yes   No (No additional information is required.)

1. If “yes” to Question #1, please describe the difficulties that your patient is likely to experience as they complete the exam and/or the specific functions that they would be unable to perform.

1. Please list the limitation(s) and/or restrictions (if any) that you believe result in a need for accommodation and explain why you believe the restrictions or accommodations are needed to take a Microsoft Certification exam.
2. Please describe any suggested accommodations that will reduce the difficulties that your patient is likely to experience during the exam:
3. Additional comments:

I hereby certify that the above statements, in my opinion, describe the learner’s need for an exam accommodation and that I am a \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ licensed to practice in the state of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

(type of provider)

Health Care Providers Signature Date