

**Texas State Board of Examiners of Marriage and Family Therapists**  
**Texas Department of State Health Services**  
P.O. Box 149347, Mail Code 1982  
Austin, Texas 78714-9347  
Phone: 512-834-6657 Fax: 512-834-6677

**Name:** \_\_\_\_\_

**Request for Disability Accommodation for National MFT Licensing Examination**

If you have a disability requiring appropriate accommodations in taking the state examination, be sure to complete this form along with the application. **In addition, attach a statement on letterhead stationery from a professional who is familiar with your disability.** This statement must describe the disability for which you require accommodation.

1. Do you have any disability-related needs that we should be made aware of in order to provide appropriate accommodations for the examination?  YES  NO If the answer is YES, please specify.

Disability: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Have you had any prior accommodations for your disability in an examination setting?  YES  NO  
If you answer YES, specify the type of accommodation. Have a professional familiar with your disability complete this information, if needed.

| Disability | Type of Test Accommodation |
|------------|----------------------------|
| _____      | _____                      |
| _____      | _____                      |
| _____      | _____                      |

3. If you have NOT had prior accommodation for a test, what do you feel would aid you in taking the examination? If you cannot answer this question by yourself, have a professional who knows your disability and the type of accommodation you need help answer this question. This professional could be a physician, psychologist, rehabilitation counselor, or other professional.

| Disability | Type of Test Accommodation |
|------------|----------------------------|
| _____      | _____                      |
| _____      | _____                      |

Please sign and date the bottom of this form. Make sure the professional who helps you complete the form also signs and dates this form. **Be sure to submit a statement on letterhead stationery from a professional who is familiar with your disability.**

Signature (Applicant) \_\_\_\_\_ Date \_\_\_\_\_

Signature (Professional) \_\_\_\_\_ Date \_\_\_\_\_