Test Accommodations: A More Inclusive Approach to Documentation Requirements©

John A Hosterman, PhD

Paradigm Testing

Donna A Morere, PhD

Department of Psychology, Gallaudet University, United States (retired)

Heather Case, DVM, MPH, DACVPM, CAE,

Disability Equity Advocate

Nicole Chestang

Graduate Management Admission Council (previous)

GED Testing Service (previous)

Tamika Hughes, MSS, MLSP, LSW

Equity & Inclusivity Champion

Correspondence: John Hosterman, PhD is Chief of Disability & Accessibility Services at Paradigm Testing.
Email: john@paradigmtesting.com

Abstract

The determination of the need for disability-based accommodations for high stakes tests is a complex process. Such determinations are particularly challenging in the area of tests for certification and licensure in fields which are regulated and where public health and safety are paramount considerations. There is no established standard process for making such decisions. While some entities use a rigid, medically-oriented approach requiring a formal medical or psychological diagnosis and involvement of medical or mental health professionals, other testing organizations have begun to adopt a more flexible approach, allowing information from professionals such as employers or university advisors who know the applicant well to write letters of support. While the medically-oriented approach would seem to offer more standardization of the process, it is often inaccessible to those with limited financial resources and may not, in the end, provide the kind of individualized documentation that would be most helpful for making test accommodations decisions. This paper reviews the definitions and models of disability, the goals of testing accommodations, and the current processes used to make accommodation determinations, and presents some more recent strategies and potential future approaches that may provide more equitable access to disability accommodations.

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Many organizations that sponsor certification or licensure tests ("test sponsors") actively promote policies to encourage wider representation in their professional fields. For example, the Certified Financial Planner Board of Standards indicates that their organization is "working

to build and diversify the ranks of financial planners, so we can meet the needs of increasingly diverse consumers" (CFP Board, n.d.).[1]

The Alliance for Responsible Professional Licensing (ARPL) in 2021 collaborated with the internationally recognized research firm Oxford Economics to publish *Valuing Professional Licensing* (Oxford Economics, 2021). This report shows how licensure itself can foster wider representation in professional fields. The report found that professional licensing is associated with higher wages across all professions and occupations. Licensure sets a clear, consistent level of qualification and removes subjectivity. Licensure is also an important tool that helps build *pay equity* (Oxford Economics, 2021).

Likewise, professional schools that are preparing their students to enter the workplace are paying attention to inclusion of historically-under-represented groups. Palmer College of Chiropractic (2024), perhaps the nation's premier chiropractic college, has specific goals for recruiting and retaining both students and faculty from historically underrepresented groups.

The authors have become aware of a growing concern from both test-takers of certification and licensure exams ("candidates") with disabilities as well as from test sponsors,

[1]*The authors acknowledge that different countries may use different language when referring to adaptations to the test or testing environment. For the purposes of this article, the terms "test accommodations", "access arrangements", and "reasonable adjustments" are used interchangeably.*

Likewise, while some in the US favor "person first" language, such as "person with a disability", other parts of the world prefer "disabled person" to emphasize the collective cultural identity and political significance. The social model of disability, described in this article, acknowledges that a disability arises from disabling environmental, attitudinal, or cultural factors. The authors acknowledges that identity is multi-faceted and thus individual preferences with respect to terminology may differ. In this article, the "disabled person" and "person with a disability" are used interchangeably.

that accommodations policies themselves could present barriers to access for some individuals. In particular, disabled candidates have complained that the cost of obtaining the required documentation to support their need for accommodations is beyond their reach.

A number of key questions provided the impetus for this paper. First, regarding the provision of disability-related accommodations on tests, do some credentialing organizations have policies that reward candidates who have wealth, knowledge, and access to diagnostic resources? And if so, what is the historical basis of these policies? If the accommodations policies at testing organizations mirror those of academic institutions, are these still appropriate for working adults? Is there an alternative framework that might be more appropriate for this adult population, and that does not depend as heavily on having access to expensive diagnostic resources?

This paper will examine the origins of accommodations policies and explore how these policies are perpetuated into the credentialing space. Finally, we will highlight organizations who have crafted accommodations policies that are more inclusive-- which benefits not only historically underrepresented groups in their professions but other test-takers as well.

What is a Disability?

Legal Models of Disability

The Americans with Disabilities Act (ADA; Americans with Disabilities Act, 1990) defines a person with a *disability* as a person who has a physical or mental impairment that substantially limits one or more major life activities. Similarly, the UK's *Equality Act (2010)* defines disability as a physical or mental impairment that has a *substantial* and long-term

negative effect on the ability to do normal daily activities. Other developed countries have similar legal definitions.

There are other ways to conceptualize *disability* that are not based on legal definitions, governmental interpretations of laws, or court opinions. In fact, reasonable, appropriate, and individualized accommodations can be designed so that the disabled person has equal access, without needing to perform a detailed analysis of each jurisdiction's laws or consulting an attorney for every situation. This is especially important for multi-state and multi-national testing organizations, where "equal" access also implies fairness and consistency in policies across jurisdictions.

Medical Model of Disability

The "medical model" of disability suggests that a person has a "disorder", an "illness", or a "condition"—there is something inherently "wrong" with the person—and that, in turn, makes them disabled (Goering, 2015). This perspective often is seen as producing isolation, exclusion, and a sense that individuals with disabilities are "less than" their non-disabled peers. This can be associated with negative views of disabilities, including an assumption of lower competence or intelligence, and the expectation that the individual will view their own disability in a negative light.

In the United States in particular, some health care providers seem to believe that a diagnosis automatically confers disability status on a person. For example, documentation to support an accommodations request may consist of little more than a note from a health care provider. The clinician may simply state, with no further elaboration, that "This is a note to

confirm that T.X. has a history of anxiety and attention deficit disorder and therefore is qualified as a person with a disability under the ADA. It is recommended that she be given extra time to take her exam." Courts have rejected this false equivalence. "Diagnosed disorders do not satisfy the ADA's definition of a disability unless they substantially limit one or more major life activities as compared to the general population." [See 28 C.F.R. § 36.105(a) (2016); *see also Mann v. La. High Sch. Athletic Ass'n* (2013) holding that a doctor's diagnosis of an anxiety disorder "is insufficient, standing alone to support a finding" that the plaintiff is likely to succeed in proving a disability under the ADA."]

Social Model of Disability

The social model of disability was developed by disabled people in direct opposition to the medical model of disability. In the social model, "disability" is seen as an *environmental or societal barrier to access*.

For example, a person who uses a wheelchair is only disabled in so far as her access to buildings is restricted by a lack of appropriate wheelchair ramps. A person who is deaf is not disabled because he cannot hear—but because other people don't know sign language or refuse to provide visual cues. Thus, the social model views disability as *the interaction between a person's functional limitations and specific barriers to access* (Samaha, 2007). In isolation, the person's physical or mental limitations do not cause the disability; a disability emerges when the limitations are combined with environmental factors which limit the person's access or full participation. Haegele and Hodge (2016) reviewed the medical and social models of disability and offered a table comparing the perspectives on a variety of factors such as the definition of a

disability and the effects not only on the individual with a disability, but also their abled peers and society. Haegele and Hodge present the social model as offering the individual with a disability increased autonomy and encouraging increased inclusion in society.

The United Nations Convention on the Rights of Persons with Disabilities (CRPD; United Nations, 2022), while not defining "disability" per se, describes people with disabilities in *relational* terms: A person is disabled due to the *interactions* and relationships with other people and/or their environment (Lawson & Beckett, 2021). The Convention recognizes that people with disabilities include those "who have long-term physical, mental, intellectual or sensory impairments" and who encounter *barriers* which hinder their "full and effective participation in society on an equal basis with others" (United Nations, 2022, Preamble, recital (e) and Article 1).

The United Nations CRPD has expressed concern about some countries' system of disability determination (for the purpose of public assistance, for example)—systems that overly rely on decontextualized medical assessment of individual impairment, rather than a social-contextual assessment that investigates the person's functional challenges in relation to barriers they face in the environment (United Nations, 2022). "The underlying message [from the CRPD] is that any disability assessment should reflect a social-contextual rather than an individualized [medical] approach" (Waddington & Priestley, 2021, p. 4).

> *[Disability] assessments that de-contextualize the person from their environment are at odds with the interactive concept of disability. This is most apparent where medical assessments rely on categorical diagnoses of impairment, in isolation from a*

> *consideration of disabling barriers. Such assessments are not compatible with the CRPD approach.* (Waddington & Priestley, 2021, p. 5)

However, it is exactly this medical approach to disability assessment that is most commonly used in the US. Moreover, these different models of disability suggest very different approaches to the process for determining appropriate accommodations, as well as the types of documentation that might be needed to support requests for accommodations. This article examines the role that sponsors of high-stakes tests have in furthering this medical approach, and we will present alternative approaches that are both consistent with disability laws as well as more consistent with the social-contextual approach outlined by the UN.

The Purpose of Testing Accommodations

The purpose of accommodation is to reduce barriers to promote equal access and full participation. How this is *operationalized* depends on the individual with the disability and their unique challenges, the nature of the task, its purpose, and the specific setting. Some disability advocates argue that "once accommodated, always accommodated" (U.S. Department of Justice, n.d.). However, not all tests are the same, or have the same purpose, nor are they all administered in the same setting. It is critical to perform an individualized analysis for each test accommodation request, taking into consideration the person's current functional limitations *in relation to* the current task and its requirements, and potential barriers to access for the specific setting involved.

The purpose of accommodation is not to ensure any particular *outcome* (finishing a test, earning a particular score, or "reaching one's fullest potential"). The ADA and related disability

laws are outcome-neutral. For example, the State of Washington describes "reasonable accommodations" in college programs and services as “modifications of programs, policies, practices, and procedures that enable qualified students with a disability to have an equal opportunity to benefit from and have access to college programs and services” (Washington State Legislature; 1996 (3)). Thus, the State of Washington’s definition emphasizes that the purpose of accommodation is to enhance access, not to guarantees any particular *outcome*.

Test candidates who request disability-related accommodations almost always want extra time, regardless of the type of test, its purpose, the setting, or the person’s particular impairment. In a survey conducted by the primary author in 2015, for accommodations requests to a credentialing organization during a one-year period, over 90% included a request for some degree of extra time on the exam. Ironically, we see many requests for significantly lengthening a person’s seat time on the exam even when the person’s own evaluator has indicated that the person has *trouble sustaining their attention over time,* or in cases where prolonged sitting can exacerbate a person’s medical condition. —That is, the exact same accommodation, extra time-- is requested by virtually all test-takers, regardless of the nature of their disability, the task, or the setting.. Research has found that many if not most students can benefit from extra time on tests such as the SAT and ACT, *whether or not they are disabled* (Sireci et al., 2005).

Documenting the Need for Accommodation: A Chronology

Although this should be obvious, not all tests are the same. In academic settings, tests are administered in classrooms, for the purpose of measuring learning and informing future

instruction. Unlike the high-stakes test settings, which follow the ADA-based intent of providing access rather than success, test accommodations and support services in academic settings are typically designed to assist students to demonstrate their knowledge and otherwise be "successful". Schools and institutions of higher education may offer a variety of support services to their students to foster success, such as tutoring, preferential course registration, preferential housing, accommodations, and modifications. An academic institution can offer accommodations and support services beyond what the law requires, and/or choose to provide accommodations and services even to students who have not been determined to have a disability. In the authors' experience having reviewed thousands of accommodations requests for high-stakes testing organizations, it is clear that many colleges and universities have not performed a detailed analysis to determine if applicants for academic accommodations are disabled as per the ADA. As noted in Doherty v. National Board of Medical Examiners (2019), the fact that an academic institution has provided accommodations and support services does not necessarily mean that the institution has done a careful analysis and determined that the person receiving services is *disabled* as per the ADA.

The accommodations policies of credentialling programs may have their roots in the policies of institutions of higher learning and entrance exam programs, which in turn may have policies that are based on those from K-12 educational programming. By better understanding where these policies originate, we can begin to understand how to make appropriate modifications to policies and procedures to better reflect the adult populations that take certification and licensure exams.

Kindergarten through high school ("K12")

A critical aspect of ensuring equitable opportunities for students with diverse needs in primary and secondary educational settings (K-12) is the provision of support services and accommodations to students with disabilities. In this context, modifications or adjustments made to the regular learning environment are designed ensure that students with disabilities have equal access to educational opportunities. Heightened awareness of disabilities and increased advocacy efforts have empowered more students and their parents to seek accommodations and other support services that foster success. The provision of disability services in K-12 settings is supported by a robust legal framework designed to ensure that students with disabilities have equal access to educational opportunities and are not discriminated against based on their disabilities. The legal basis of these includes the Individuals with Disabilities Education Act (IDEA; Individuals with Disabilities Education Act, 1975) and Section 504 of the Rehabilitation Act of 1973 (Rehabilitation Act, 1973).

IDEA (1975) mandates that students with disabilities receive a free and appropriate public education, including the provision of necessary accommodations and support services to meet the unique needs of each student. It emphasizes the use of Individualized Education Programs (IEPs) to tailor educational plans to students with disabilities. By contrast, Section 504 (Rehabilitation Act, 1973) is a federal civil rights law that prohibits discrimination against individuals with disabilities in programs and activities that receive federal funding, mandating that schools provide accommodations to students with disabilities to ensure they have equal

access to education. This can include adjustments to classroom materials, the physical environment, accessibility tools, and accommodations.

Accommodations in K-12 settings may take various forms, catering to the specific needs of each student. Examples include extended testing time, preferential seating, assistive technology, modified assignments, and alternate formats for materials. Additional support services may be available to qualifying students, such as reading remediation, tutoring, speech/language assistance, and counselling. The goal of these types of services and accommodations is to customize the learning environment and the support services to enable students to participate in educational activities and assessments on an equal basis with their non-disabled peers (U.S. Department of Education, 2019).

Students in public K-12 environments might undergo a comprehensive assessment. This may involve medical or psychological evaluations, educational assessments, and consultations with relevant specialists. A formal diagnosis, indicating the presence of a qualifying disorder, is often a prerequisite for the approval of accommodations or other services.

In recent years, there has been a noticeable surge in the number of students requesting disability accommodations at both the K-12 and post-secondary level (Chan, 2016; Miller et al., 2019; Miller et al., 2015; Shifrer, 2022; Zirkel & Weathers, 2016). Several factors have contributed to this trend, including increased awareness and acceptance of mental health conditions, changes in diagnostic criteria, a growing recognition of the importance of accommodating diverse learning needs, and a shift to the use of accommodations instead of interventions.

In addition, there has been an increased interest on the part of some students and parents to ensure they have all advantages that could positively influence current or future success (see e.g., Lovett, 2021). Parents have a strong motivation to seek every possible resource to give their children an advantage. This motivation is often facilitated by doctors, psychologists, and other clinicians to advocate for accommodations and support services for their clients. For a variety of reasons, clinicians may be willing to recommend accommodations and support services despite adequate data to support such suggestions; this includes financial interest, avoidance of conflict with parents, empathy with the client, and confirmation bias (Lerner, 2019; Lovett., 2022). Furthermore, clinicians may be misled by intentional attempts to appear disabled. In addition to a range of information on how to "fake" ADHD available on the internet a recent major scandal involving wealthy parents some students received coaching to feign disabilities. For example, Price (2020) noted that Rick Singer, the college admissions advisor involved in the scandal, "coached students to pretend "to be stupid, not to be as smart as [they are]" during evaluations in order to procure learning disability diagnoses (p.464)." The article further reported that disability rights advocates worry that such misuse of accommodations may have deleterious effects on students who truly need them.

If parents are not satisfied with a school's assessment or have a child in a private school, the family can pursue an independent evaluation if they have the financial means and available community resources. The cost of an independent psychological evaluation can sometimes approach $5,000, an impossible hurdle for many families (Parents, 2022). [The authors

acknowledge that in some countries, government funding is available for psychological assessments for children and university students, which can help mediate disparities.]

Families with significant financial resources may not have difficulty locating and paying for private evaluations to ensure that their children are diagnosed with *something* and have documentation to support a request for accommodations (whether that request is supported by the evidence or not). A recent *New York Times* article cited the increased demand for and access to disability accommodations in affluent communities, creating a "wealth gap" in K-12 schools who have students with 504 Plans that provide for extended test time:

> *"A sharp disparity in accommodations [rates] raises the question of whether families in moneyed communities are taking advantage of the system, or whether they simply have the means to address a problem that less-affluent families cannot. In the country's richest enclaves, where students already have greater access to private tutors and admissions coaches, the share of high school students with a [disability] designation is double the national average.*
>
> *The Times found a glaring wealth gap in 504 designations. At high schools in the richest school districts — the top 1 percent as measured by census income data — 5.8 percent of students held a 504 plan, more than double the national average of 2.7 percent. Some wealthy districts had 504 rates of up to 18 percent. There were also racial disparities, The Times found. A larger percentage of white students held a 504 plan than students of any other race.* (Goldstein & Patel, July 31, 2019)

In addition to financial barriers to accessing appropriate disability documentation, students who come from less-privileged families may not even know *how* to access an independent educational or psychological evaluation. This may be particularly true of "first-generation" students (Lombardy et. al., 2012). And even if there is awareness of potential resources, in some communities, the social stigma surrounding disabilities can create reluctance among students and parents to pursue support services or accommodations (Saetermoe et. al., 2001). Clearly the literature and research describing first-generation students with disabilities is quite limited, as described by Pinion (2022) in a doctoral dissertation.

Knowing that a "paper trail" is necessary for obtaining accommodations in future academic settings and on future high-stakes tests, affluent families may be motivated to have their children diagnosed with a disorder prior to taking college entrance exams, and then petition for their children to receive accommodations on those tests. Numerous private college counselling firms have helped parents ensure their children get the documentation to support a request for accommodations on the SAT and ACT exams (e.g., see Summit Prep, 2024; Ivy Lounge Test Prep., 2023; Impact Parents, 2020).

K-12 schools may feel pressure from parents to readily accept documentation that is obtained from private sources, such as medical providers and independent psychologists—then to provide whatever services and accommodations that the parent's professional recommends (Lewis & Munez, 2023). "Bulldozer parenting" has become the norm among privileged families (Miller & Bromwich, 2019). This can solve an immediate problem-- a struggling student, or one who is perceived to "not be working up to their fullest potential" -- but can lead to *learned*

helplessness and an over-dependence on accommodations, rather than learning the skills necessary for long-term success (McGlynn & Kelly, 2019). As stated in the *Times*,

> *Section 504's broad eligibility criteria, lack of funding, and substantial deference to the professional judgment of educators and external evaluators have favored powerful and privileged families. Federal disability law allows affluent parents, families, and students to leverage their power and privilege to pursue accommodations when needed—and even when they're not. At the same time, federal law can leave minority caregivers who lack resources, such as money to pay for private evaluators, unable to access 504 accommodations, including extended testing time.* (Miller & Bromwich, 2019)

While the *Times* and others have suggested that affluent parents and wealthy schools may be fueling the stampede for testing accommodations, there are questions about the extent to which universities and high-stakes testing organizations may also be partly to blame, as they enact disability documentation policies that reward those who are able to produce a costly psychological evaluation report.

Further & Higher Education

Most colleges and universities in the US, Canada, and other developed countries have a disabilities services office for students. These offices arrange potentially-numerous accommodations and support services to students, from extra time on tests, to preferential campus housing and priority course registration, to math tutoring and help writing term papers. Colleges report dramatic increases in the numbers of students who are asking for disability-

related accommodations, especially extra testing time. For example, the *Wall Street Journal* reports that Pomona College, an elite private institution, had more than a four-fold increase in accommodations requests from 2014 to 2018 (Belkin, 2018). Belkin reports of massive increases in accommodations requests, to epidemic proportions. "At the University of Minnesota, a test center for students entitled to low-distraction environments or extended time on exams administered 9,681 tests [in 2017], nearly double the number in 2013. The growth has forced staff to give up their offices during finals to make room for students. This past year, the school rented out an additional 10,000 square feet of space in a nearby hotel (paragraph 10)."

Colleges are highly motivated to help their students succeed, as this impacts retention rates, graduation rates, and college ratings (Morse & Brooks, 2023 September 17 a, b). The inherent lack of neutrality and pressure to help students be successful at any cost means that there could be significant "over-accommodating", as colleges rush to help their students succeed by any means available. Guidelines for documentation needed to support accommodations at university typically involve gathering historical evidence, such as verification of accommodations or special education support services in the K-12 setting, and medical or psychological diagnostic information. Given that students from affluent and well-connected families may be better-positioned to have extensive diagnostic documentation to support accommodations requests at university, the focus turns to the extent to which colleges and universities may be rewarding those students who have such documentation, and conversely,

the extent to which those institutions may have accommodations documentation policies that present barriers to less-privileged students.

Despite professing to use the contextual and relational approach of the social model of disability, colleges and universities often follow the medical approach. For example, Iowa State University's (n.d.) website for students with disabilities states explicitly, "*All academic accommodation requests require medical documentation*."

Similarly, the University of Washington (2001) has published an article that openly muddles the concepts of diagnosis and disability and refers to students with a "mental illness" as automatically being disabled and entitled to various academic accommodations. Not surprisingly, the University of Washington's guidelines for documenting psychological disorders suggest that medical or psychiatric professionals are best suited to provide evidence of the "illness" afflicting these students. The guidelines indicate that a healthcare provider's documentation, such as an "official visit summary" or "emergency department discharge paper" would be sufficient to establish a need for accommodations, presumably irrespective of their actual functional limitations, the setting, or the task demands. Alternatively, a student could undergo a potentially expensive "psychological evaluation" to document the "illness" and to support the need for accommodations.

Also doubling down on the medical model of disability, the Ohio State University (OSU, 2024a) suggests that appropriate documentation "should include proof of diagnosis" from a medical or mental health professional. While this requirement is part of a process, the requirement for a diagnosis alone may present a barrier to those with limited resources. OSU's

guidelines indicate that it may be helpful to have information about the "medication or medical treatment" being used by the student, "copies of medical records", and a "patient portal diagnostic summary." OSU (2024b) offers students the ability to have their diagnostician complete a form, which asks about diagnosis, medications currently prescribed, and current treatments. OSU's guidance provides no rationale for gathering this sensitive medical or mental health information— that is, an explanation that would tie the diagnosis to the need for accommodations. In the end, this is the medical model's downfall: Medical and mental health diagnostic information ultimately provides little useful information for determining appropriate accommodations, particularly for adults. Simply knowing what a person has been diagnosed with tells us nothing about what accommodations they may need for a particular task or in a specific setting.

In contrast to US universities such as those cited above, at many universities in Canada, due to a legal settlement between a student with a disability and York University, a specific medical or mental health diagnosis is not required, and accommodations can be requested *without furnishing any diagnostic evidence* (CBC, 2016). For example, the University of Toronto's website clearly states, "Disclosing a diagnosis is a choice and is **not** required to receive accommodations." Likewise, Queens University states, "Disclosure of a diagnosis is not required."

Instead, the focus shifts to an analysis of the student's current functional limitations and how these could negatively interact with specific barriers to access and full participation. Through a collaborative, interactive process, disability-service staff and students with disabilities

can review together the documentation that the student discloses, their current functional challenges, potential barriers to access, and the services or accommodations that may be needed—all without the need for sharing medical diagnostic information per se. Since potentially costly diagnostic evidence is not required, students from diverse economic and cultural backgrounds can potentially receive academic assistance.

Similarly, some universities in Europe have embraced the Social Model of Disability and incorporated this into their policies and procedures for educating disabled students. For example, the University of Dundee (UK) declares,

> *The University is committed to providing an inclusive and equitable learning environment that enables disabled students to access the same opportunities as their non-disabled peers. The University is also committed to the Social Model of Disability, where the emphasis is on removing the disabling effects of the environment rather than assessing the impact of individual impairments.* (University of Dundee, 2021)

Here, the emphasis is on identifying and removing barriers to access—rather than performing a detailed medical or psychological analysis of an individual's medical condition or second-guessing the student's diagnostician or the veracity of the diagnosis itself.

Entrance Exams

College entrance exams, such as the SAT or ACT, are tests designed to predict the likelihood of a person's success at a future college or other academic institution (Noble and Sawyer, 2002), and to inform such institutions of the relative competence of test-takers in skills

and abilities that will be important in those institutions. Most test-takers are children in high school. The *Wall Street Journal* reports enormous increases in the volume of accommodations requests on entrance exams. From 2010 to 2023, the number of accommodations requests jumped 171% at the College Board, which administers the SAT (Belkin, 2018).

Graduate school entrance exams, such as the Medical College Admissions Test (MCAT) and the Law School Admissions Test (LSAT) are designed to predict the likelihood of a person's success at a future graduate academic institution, and to inform such institutions of the relative competence of test-takers in skills and abilities that will be important in those institutions (Hanson et. al., 2022). Not surprising given the dramatic increase in numbers of accommodations requests at colleges and on college entrance exams, graduate school entrance exam programs have also seen a startling increase in the volume of test accommodations requests. For example, the Law School Admissions Council, which administers the LSAT, reports that the number of requests for accommodations *doubled* in five testing years from 2012–2013 to 2016–2017 (Lauth, Sweeney, & Reese, 2024).

These phenomena are not limited to the US. The Membership of the Royal College of General Practitioners (MRCGP) test for post-graduate medical qualification (that is, medical licensure) in the UK has seen more than a 300% increase in requests for access arrangements (accommodations). For the academic year 2015-16, 5.6% of all attempts at the MRCGP Applied Knowledge Test (AKT) were undertaken by candidates who declared a disability, compared to only 1.8% of all attempts in 2010-2011 (Academy of Medical Royal Colleges, 2018, May).

The medical approach to documenting a need for accommodations is prevalent. US-based entrance exams usually require diagnostic evidence from a medical or mental health evaluator. For example, at the Graduate Management Admissions Council, which administers the Graduate Management Admissions Test (GMAT, 2024) for graduate business admissions, accommodations guidelines specify, "Schedule an appointment or meeting with the healthcare professional who evaluated or diagnosed your disability" to obtain "a comprehensive report detailing your condition" . Likewise, the MCAT documentation guidelines for accommodations indicates, "A current comprehensive evaluation is a critical component of your application" (AAMC, 2024). For economically-advantaged, privileged, and well-connected test-takers, these requirements for a current, comprehensive evaluation are not problematic. However, not all test-takers can afford such an evaluation which, as noted above, can easily run into the thousands of dollars. The question becomes, who do these documentation guidelines favor, and conversely, who do they disadvantage?

Most entrance exam test-takers are full-time university students, although many work part-time. A Gitnux (2023) review of education statistics in the UK found that 43% of full-time undergraduate students were employed at least part-time; fully 81% of part-time college undergraduates were employed. The majority of GRE test takers are in their 20s; fully 55% of GRE test-takers are over the age of 23 (Student Progress, 2024). Given that so many entrance exam test-takers are adults and are employed at least part-time, would evidence from the employer—which would be free--be considered in the accommodations review? After all, an employer may know the person far better than a diagnostician, and may be in a better position

to document the person's actual functional challenges and what accommodations or modifications have been helpful. Other professionals in the student's life may also know the student much better than the diagnostician, such as a faculty advisor disability services counselor. These types of professionals could prepare free documentation that would provide much more valuable insights into the student's actual functional challenges and how these might manifest on a test. Students who are not as well-off financially or who are not as well-connected could certainly benefit from a more inclusive approach that allows for disability documentation to come from a wider range of professional sources.

Certification or Licensure Tests

Following the lead of universities and entrance exam programs that hew closely to the medical model of disability and that have requirements for medical or psychological evidence of a diagnosis in order to provide accommodations, organizations that sponsor certification and licensure exams may similarly require such medical evidence. These policies focus on validating the diagnosis per se, rather than determining how the person's impairment might negatively interact with barriers to access on the exam.

Indeed, in terms of documentation guidelines for accommodations requests, the medical model of disability—requiring individuals with disabilities to have their "diagnosis" or "illness" certified by a medical professional—seems to be the norm for certification and licensure organizations. For example, to apply for accommodations on the United States Medical Licensing Exam, test candidates are required to produce "Documentation from the

evaluating or treating professional… The evaluating professional should have training and direct experience in the diagnosis and treatment of adults" (USMLE, 2024).

Likewise, the National Board for Certified Counselors (NBCC, 2024) indicates that documentation should be from "A qualified professional who is licensed or otherwise properly credentialed, and possesses appropriate expertise in evaluating and assessing the disability… [and include] the specific, diagnosed disability." As was shown to be the case with Ohio State University's (2024a, b) documentation guidelines, NBCC provides no rationale for the need for this diagnostic evidence, how it will be used, and by whom. Thus, even the counseling certification board—responsible for credentialing counselors who may not be the diagnostician but who could potentially provide valuable information *to support their own clients' requests for accommodations*—has doubled-down on the medical model of disability for the process of obtaining accommodations for certification as a counselor.

Several organizations now require a "Qualified Professional Form". This form must be completed by the medical or mental health provider who "diagnosed" the person's disorder (see State Bar of California, 2024 and LSAC, 2023). The National Council of Examiners for Engineering and Surveying (NCEES, n.d.) goes one step further, requiring test candidates to have their medical professional complete a "Healthcare Provider Form" to document their illness. This Form requires extensive diagnostic evidence about "the patient"—a term that many people with disabilities would consider insulting.

The "Qualified Professional Form", "Healthcare Provider Form" and other similar forms and policies have serious disadvantages. First, these forms and policies are restrictive in terms

of focusing solely on the diagnosis—which may tell us nothing about the disabled person's actual functional challenges and common barriers to access and participation, and how these may interact with potential barriers to access on the test. As described by the UN's (2022) CRPD, the issue at hand is not the medical evidence of impairment, but an analysis of the *interaction* between the person and potential barriers to access. This analysis, by definition, will need to include information from professionals who know the person well, which may not be the diagnostician.

As suggested above, the "qualified professional" may not have a good understanding of the person's actual, day-to-day functioning. These "qualified professional" forms do not allow for *non-diagnostic* professionals who may know the person well to provide information, such as an academic advisor, a therapist, or an employer. The authors routinely see diagnostic reports from what would be considered a "qualified professional" that simply describe tests that support a particular diagnosis, but which makes it clear that the professional does not know the person well and cannot articulate the person's actual functional challenges and how these may interact with potential barriers to access on the test. Psychological reports often conclude with unsubstantiated statements such as, "Given Susan's diagnosis of ADHD, she is a person with a disability under the ADA and entitled to accommodations. I recommend 100% extra time and testing in a private room for her XXX licensing exam." Other documentation from a "qualified professional" may simply be a brief note from a doctor that states the diagnosis and re-tells the person's own self-reported symptoms and complaints. For example, common language would be, "My patient Mr. Oswald has reported significant anxiety in test-taking situations. I

recommend that he have extra time to take his exam." That is, the "qualified professional" simply re-tells the person's own subjective account and desire for certain accommodations.

A significant concern about the requirement for a "qualified professional" to provide documentation authenticating the diagnosis is the need for a potentially expensive medical or mental health diagnostic evaluation, which itself may present an additional barrier to access for low-income adults or those who are unaware of how to obtain such documentation.

Disabled adults who may have been diagnosed many years ago must obtain new documentation to confirm their diagnosis. For example, a person who has been deaf since birth—now aged 40—may not have had an audiogram since childhood. In order to comply with a credentialing organization's documentation requirements to request accommodations, they must schedule and pay for a current audiogram with a "qualified professional". This audiologist is not likely to know the person well. The audiologist focuses solely on documenting the person's hearing acuity at each frequency level. This type of medical information is essentially meaningless for determining what types of accommodations might be helpful.

The example above may seem obvious, but a parallel can be seen for adult test candidates who have attention, learning challenges, mental health struggles, or other "invisible" impairments. Certification and licensure organizations see numerous requests for accommodations based on these conditions, often with the only documentation being a diagnostic statement or report from a doctor or psychologist. For example, brief memos simply stating that "X.Y. is under my care and has [specific diagnosis]. Please provide them with additional test time" are not uncommon. Indeed, such short notes may request

accommodations such as double time, without any rationale other than the reported diagnosis and self-reported symptoms. Just as the report from the audiologist that confirms that the deaf person is in fact deaf, the note from the family doctor validating that Billy has been diagnosed with ADHD tells us nothing about his current functioning, functional limitations, or common barriers to access that Billy faces. Based only on the diagnosis itself, do we surmise that Billy needs more time on the test, because he is prone to being inattentive and often stares out the window for long periods of time? Or is Billy impulsive, such that he is prone to rushing through the test—which would suggest that an accommodation such as doubling his seat time on the exam would be counterproductive? Or, with medication, does Billy not have any significant functional limitations at all? Again, simply validating the diagnosis tells us almost nothing about what accommodations might be appropriate. Moreover, if Billy's diagnostic documentation is from many years ago, Billy will be required to undergo a new, and likely expensive, psychological evaluation, thus throwing another unnecessary barrier in Billy's way.

In contrast, certification and licensure organizations that appreciate the social model of disability are interested in gathering documentation about the person's impairment and how this may negatively *interact* with specific barriers on the test, which could limit access and full participation. For example, to support a request for test accommodations, the UK General Medical Council (GMC, 2024) requires "An original letter, certificate or medical report, from an appropriate professional confirming the nature of your health needs and the functional impact of the disability in an exam environment." ("What can we do to support you?" section). A specific diagnosis is not needed, nor is extensive medical or mental health diagnostic evidence.

Instead, the emphasis is on obtaining documentation from a professional who can articulate the functional impact of the disability and how this may interact with potential barriers when taking the exam. The recommendations for adjustments should be specific (e.g., if extra time is recommended, the specific amount of time should be stated along with "what the considerations were in reaching this figure." ("What do you need to do?" section) This presumes that the professional who supplies such documentation should be know the person well.

Likewise, the UK's *College of Policing* (2020) policy document regarding test-takers with disabilities notes the value of inclusiveness: "We encourage all candidates who feel they will need accommodations to apply for these. We are committed to supporting candidates to ensure they receive the support they need. In doing so this will help the police service to ensure they are reflective of the communities they serve and continue to value the differences of individuals" (p.4).

A review of websites of certification and licensure authorities in North America found that only a handful of have specifically abandoned the medical model of disability and its resulting requirements for medical diagnosis, and replaced them with documentation policies that are more inclusive. For example, the Federation of State Boards of Physical Therapy (FSBPT) documentation guidelines for accommodations notes,

> *Because we do not require evidence of a diagnosis, we do not require that your documentation come from a doctor or psychologist, although we will consider that. We strongly consider documentation from professionals who know you best, who can attest*

> *to the functional limitations you experience on a day-to-day basis due to your disability—such as employers, counselors, or professors.* (p. 3)

Likewise, the Pharmacy Examining Board of Canada (PEBC, 2022) makes it abundantly clear that self-reported, subjective information will not be sufficient: "Self-reporting of symptoms, including to a health professional, is not considered objective evidence" (p.1). Instead, the PEBC offers suggestions of objective information about the disability (and potential need for accommodations) from a wide variety of sources, many of which are free:

> *Depending on the nature of your disability, objective evidence includes, but is not limited to, formal psychoeducational/psychological assessments, [academic] transcripts, [other] information corroborating significant functional impairment, written letters of concern from educational [institutions], evidence of multiple traffic accidents, formal warnings from employers due to inattention/errors, [or] performance on standardized tests when no extra time was given*. (p.1)

Thus, while the PEBC requires objective evidence to support accommodations requests, it offers a range of possible sources of this evidence, which again may be advantageous to candidates who do not have the financial resources to fund a formal diagnostic evaluation. That is, while a diagnostic evaluation can certainly be considered, it is not the only avenue for documenting a need for accommodations.

More Inclusive Approaches

In our web search of documentation requirements, we found one US-based university that allows for a broader range of types of documentation to support requests for test accommodations. The University of Michigan Medical School (2024) provides guidance regarding how to document a need for accommodations-- ironically, for their medical students who are preparing to take the USMLE-- a program which, as described above, requires medical and diagnostic evidence. Despite the USMLE's insistence on submitting medical and diagnostic evidence, Michigan's Medical School seems to recognize that many of its students are adults who perhaps last had a formal diagnostic evaluation many years ago. Moreover, many of these students are incurring very significant financial debts while attending medical school, thus putting a new diagnostic evaluation out of reach for many. Instead, the Medical School suggests the following:

> *Provide additional information to strengthen your request for accommodations such as historical evidence and need for accommodation. If you were diagnosed later in life, give examples of how your undiagnosed disability affected your early life and education. Historical disability evaluations, letters from doctors, letters from previous graduate entrance exams (e.g., MCAT, GRE), IEPs, report cards with comments referring to behavioral patterns, inattentiveness, or need for extra supports may help substantiate a history of receiving formal or informal accommodations.*
>
> *A letter from a professor, advisor, or an employer providing further evidence of the impact of your disability on learning or performance while in school or on the job (e.g., a letter from a former supervisor describing performance issues or additional support*

required on the job as a result of disability-related difficulties) may help substantiate the impact of a disability, even if you were diagnosed later in life.

Transcripts should be provided if they clearly show the impact of your disability on your grades. For example, if you had a history of dropping or withdrawing from classes to maintain your GPA, this might serve as evidence that when given a reduced course load, you excelled.

Letters from professors, teachers, guidance counselors or other people who can describe your previous academic performance may be helpful if they can show how your work was impacted by the disability. If you were diagnosed later in life, if there was a professor or support person who suggested that an initial evaluation might be necessary, or who first connected you with disability related supports, a letter from that person might be helpful to contextualize your circumstances. (pp. 1-2)

Likewise, several high-stakes testing organizations have promoted accommodations policies that focus on gathering documentation from *professionals who know the candidate well*—but who may not have been the professional who conferred the diagnosis per se. For example, the Optometry Examining Board of Canada (OEBC; n.d.) states that it does not require a diagnosis and that simply having a diagnosis does not automatically constitute a disability or qualify the candidate for accommodations. The OEBC further suggests the types of documentation which could provide evidence of actual functional limitations, including verification from a professional such as an employer. While some individuals might be reluctant to disclose their disability to an employer, others might be able to discuss their disability and

access needs confidentially with Human Resources staff at their workplace. This is akin to university students disclosing their disability to disability-services staff, who then articulate the student's needs to professors.

As suggested above, rather than focusing on the diagnosis per se or the self-reported symptoms that led to the diagnosis, helpful documentation speaks to the actual functional limitations and challenges in major life activities or activities of daily living, how these limitations interact with specific barriers, and what types of accommodations have been helpful to improve access and reduce barriers. For example, an employer or the relevant human resources officer, for no cost, might write a brief letter outlining how the person's disability manifested in the workplace, and what specific accommodations or modifications were utilized to allow the person to work effectively and perform their required duties. Other examples might include a detailed letter from a faculty advisor who knows the individual well and who can speak to his actual functional challenges and the types of accommodations or adjustments that have been (or have not been) helpful to reduce barriers to access (see Appendix A for an example of this and other letters)In addition to the description of the deleterious effects of the disability on their workplace/academic functioning and the specific accommodations provided, features that make such letters more persuasive include being on business/university letterhead and the date(s) of employment or the supervisory relationship. This type of documentation provides much more useful information to the test sponsor who must make an accommodations decision than simply a diagnostic statement from an evaluator who does not know the person well. Unfortunately, this documentation would not be acceptable to

organizations that hold to the medical model, because the professional providing the documentation was not the diagnostician, and therefore, was not a "qualified" professional.

For those involved in reviewing disability-related requests for accommodations on licensure tests, the focus is on access. Questions might include,

- What are the person's *current functional limitations*?
- What evidence (documentation) that indicates that the current functional limitations are in fact limitations to *major life activities* or activities that are central to daily life?
- What are the potential interactions between those functional limitations and specific barriers to access on the licensure exam?
- What accommodations might reasonably be expected to reduce those barriers?

For the past several years, the University of Arizona has been piloting and studying the results of a new exam for law school admissions called JD-Next. "Though a standardized test (LSAT or GRE) is still required by the American Bar Association for admission to law school, as of November 2023, 46 law schools have obtained variances (exceptions) to this rule to accept JD-Next (Spivey Consulting, 2023, paragraph 2)". Thus, if you are applying to these law schools, you may have the option to take the JD-Next course and exam in lieu of the LSAT or GRE.

JD-Next aims to be a more inclusive, representative gauge of law school success than the LSAT. The JD-Next program's stated goals are:

- Prepare all populations for success [in law school] by giving them foundational knowledge and skills.
- Reduce any potential racial and class disparities in preparation for admissions testing

- Create a valid and reliable predictor of performance in law school. (Aspen Publishing, 2024a, Benefits of JD-Next section)

The JD-Next program offers a self-paced course, followed by a high-stakes test; both must be taken, consecutively. Aspen Publishing's website states that the JD-Next is a separate JD admissions exam which "produces little to no score gap between minority and majority racial and ethnic groups, thereby promoting equity and diversity in a post-affirmative action world," and "Multiple validity studies have shown that JD-Next test scores are strong predictors of law school grades and can provide a significant increase over existing admissions tools in the ability to predict law school academic performance" (Aspen Publishing, 2024b, Why JD-Next? section).

The JD-Next program has accommodations documentation guidelines that are exceptionally inclusive, and these might provide a roadmap for other high-stakes testing programs (Aspen Publishing, 2024c). Although diagnostic evidence may be considered in the accommodations review process, it is not the *only* avenue for documenting a need for accommodations. The JD-Next program encourages candidates with disabilities to submit documentation from a professional who knows them well:

> *Instead of focusing on your diagnosis or the self-reported symptoms that led to it, this documentation should address your* ***current functional limitations and challenges*** *in major life activities or daily living activities (not just test-taking), how these limitations interact with specific barriers, and what types of accommodations have been effective in improving access and reducing barriers. This documentation should come from a professional you interact with regularly.*

Please note that a specific diagnosis is not required, *and accommodations decisions are not based on any particular diagnosis. Additionally, a formal diagnostic evaluation is not required for the Short Process.* (Short Process for testing accommodations section)

The JD-Next program's documentation guidelines allow for multiple pathways to documenting a need for accommodations, and many of the possible sources of documentation are free (Aspen Publishing, 2024c). Possible sources of evidence include,

A letter or report from any of these professionals who know you well:

- ☐ Employer or internship supervisor
- ☐ Medical or psychological professional
- ☐ Therapist or related mental health professional
- ☐ Vocational counsellor
- ☐ Psychologist
- ☐ Rehab counsellor
- ☐ Physical therapist
- ☐ Faculty advisor
- ☐ Disability Services staff person
- ☐ Educational therapist
- ☐ Nurse Practitioner, Physician Assistant, or other medical or mental health professional involved in your ongoing treatment, therapy, or assistance programming

JD-Next's documentation guidelines specify what types of information would be helpful, from the professional who knows the candidate well:

1) ***How the professional knows you well****: The professional's relationship to you, how often this person has interacted with you over the past 12 months, and detailed information that demonstrates that they know you well (i.e., your employer who interacts with you in the workplace every day)*
2) ***Your current levels of functioning*** *in the setting in which the professional knows you well*
3) ***Current functional limitations*** *and challenges in the setting in which the professional knows you*
4) ***Current barriers to access*** *in the setting in which the professional knows you*
5) ***Accommodations or modifications*** *in the setting in which the professional knows you*
6) ***Anticipated barriers to access*** *on the JDN exam, and how the requested accommodations will mitigate those barriers* (Column A, part D)

Rather than insisting on a diagnosis and evidence to support the validity of the diagnosis, JD-Next specifies,

- Documentation that focuses mainly on your medical or mental health *diagnosis* will not be helpful. The focus should be on a discussion of your <u>functioning</u>.

- A letter from an evaluator, such as a doctor or psychologist, who only knows you from the context of a *diagnostic* evaluation, and that only describes your *diagnosis*, will not be helpful. (Column A, part E)

Because these guidelines include multiple avenues for a candidate to provide documentation of their disability and need for accommodations-- many of which can be obtained for free-- candidates from more diverse backgrounds and financial situations have an opportunity to apply for the accommodations they need to more fully participate.

Conclusions & Recommendations

Certification and licensure help ensure the protection of the public. Credentialling is an important tool to ensure that individuals entering complex or specialized positions in the workplace have appropriate knowledge and skills to practice safely and competently. Credentialing serves to set a clear and consistent level of qualification, removes subjectivity, and builds pay equity. For adult learners from disadvantaged backgrounds, certification and licensure is an important key to their long-term success in their chosen profession and is a critical determinant of their future financial wellbeing.

The authors offer the following conclusions and recommendations.

1. US-based testing programs often adhere to the medical model of disability. The medical model views a disabled person as “defective” or “broken”, in need of support services in order to compensate for their deficiencies. These views are outdated, offensive, and ultimately do

not contribute to a testing program's goal of gaining a better understanding of the disabled person's accommodations needs.

Recommendation: The social model of disability is superior and should be used to inform documentation requirements. The social model views "disability" as the *interaction* between the person's limitations and environmental (or attitudinal) barriers to access. By requiring documentation that provides a better understanding of this interaction, testing organizations can elicit more useful information when determining what accommodations might be appropriate.

2. Many US-based testing programs continue to require diagnostic evidence. A formal diagnosis, by a "qualified evaluator" indicating the presence of a disorder, is often a prerequisite for the approval of accommodations. Following the approach of many universities, testing organizations require that test-takers seeking disability-related accommodations undergo a comprehensive assessment that involves obtaining potentially-expensive medical or psychological evaluations.

Medical and mental health practitioners who gather diagnostic information often do not explain how this correlates with a person's actual "real world" functioning. In particular, psychological evaluations are routinely administered by professionals who do not know their clients well, do not consider collateral or corroborating information from other sources, and do not explain how test results correlate with evidence of actual functioning and functional limitations. The authors routinely see psychological reports that indicate that third-year law school students have an IQ in the mentally retarded range, or who have reading skills at the 4th

grade level-- results that do not in any way correspond with their actual levels of functioning and are simply not credible. By overly weighting the conclusions of a diagnostician who does not know the person well, the documentation to support accommodations requests can lead to inappropriate accommodations decisions.

Recommendation: A diagnosis should not be required. A valid diagnosis does not automatically confer disability status, irrespective of jurisdiction. More importantly, simply knowing a person's diagnosis does not provide much useful information for determining what test accommodations might be appropriate. The process of determining reasonable accommodations should involve a careful, individualized, holistic approach, rather than an approach that is more akin to "following a recipe".

3. The notion of a "qualified professional" is misguided. Perhaps stemming from the LSAC consent decree (DEFH v. Law School Admission Council, Inc., 2014), some certification and licensure organizations require that supporting documentation come from a "qualified professional"—meaning a licensed medical or mental health diagnostician. This individual may not know the person well, if at all. The process of diagnosis may be limited. The authors commonly see diagnoses rendered following nothing more than a brief online interview, a visit with a family doctor that involves completion of one or more symptom inventories and checklists, or a one-day evaluation with a psychologist who does not consider other sources of information. While these professionals may be qualified to render a valid diagnosis, they are not qualified to provide detailed documentation about the disabled person's actual functioning

common barriers to access they face, and recommendations for test accommodations that have a logical (not just diagnostic) basis.

Recommendation: Testing programs need to redefine who is a "qualified professional." A qualified professional should be a person who knows the person with a disability well, in a professional capacity—irrespective of whether this was the same individual who "diagnosed" or is "treating" the person. There are many potential sources for this documentation. For example, for the person who is deaf who needs to attend parent-teacher conferences at his daughter's school, the school's principal could write a letter indicating that she knows the deaf parent, and that the parent needs a sign language interpreter in order to participate in these meetings. This is a (free) letter from a professional who knows the person well and who can describe the functional limitation and barriers to access, without the need for a medical evaluation or a specific diagnosis. For adults who are *disabled*, this process of gathering supporting documentation should be simple and straightforward.

A "qualified professional" is not a friend or family member but is a person who knows the disabled person well, in a professional capacity. In our experience, a detailed letter from a professional who knows the person well can provide much more useful and relevant information for the purpose of making an accommodations decision than simply naming a diagnosis or listing various test scores. For example, the authors have seen letters from employers, co-workers, faculty advisors, therapists, and other professionals—who may not have been the *diagnostician* per se—but who know the individual well, and can speak to their functional challenges, common barriers to access, and the types of accommodations or

modifications that have been helpful to reducing barriers. This type of documentation can typically be obtained for no cost and is more readily available.

4. More information is needed from testing organizations. The authors conducted a non-scientific review of a number of test sponsors' accommodations policies. While our findings consistently showed the dominance of the medical/diagnostic approach to substantiating requests for test accommodations, and little regard for evidence from other (non-diagnostic) sources, our review was not comprehensive.

Recommendation: Conduct a survey of the accommodations policies of testing organizations. The survey should include information about the types of supporting documentation that is required for requesting accommodations, and the extent to which organizations might consider "alternative" (that is, non-diagnostic) professional information. Such a survey could also gather information about the extent to which accommodations/accessibility staff interact with other staff who are engaged in the work of broadening representation in the field, to include historically-underrepresented populations. Finally, the survey could potentially identify testing organizations who have taken a more progressive approach to their documentation requirements and could be a "model" for other organizations that might consider updating their accommodations policies.

The authors are currently undertaking such a survey. Results will be forthcoming in a future manuscript.

Final thoughts

The authors, collectively, have heard for many years from adult learners and adult test candidates the concern that the process for applying for test accommodations is cumbersome, expensive, and limiting. We agree. These policies and processes are the result of several factors, including a legacy of an approach used by schools for children and young adults, including those at US-based universities and the K-12 educational system. Other processes adopted by US-based certification and licensure organizations are apparently based on the misguided perception that following the guidelines of one institution's consent decree will somehow inoculate them from a legal challenge by the US Department of Justice. Even the DoJ's own guidance to testing organizations (U.S. Department of Justice, n.d.) succumbs to the outdated medical model of disability with its inherent barriers to adults with disabilities who are trying to obtain supporting documentation.

There are better ways for adults to document the need for testing accommodations on credentialing tests-- one that focuses, rightly, on an analysis of a person's actual functional challenges, how these interact with common barriers to access, and what accommodations might be helpful in the testing setting to reduce potential barriers to access.

Rather than opening the floodgates, programs who adopt this alternative approach could see a *rebalancing* of who is accommodated. Individuals who are *not* disabled, but who only can provide diagnostic evidence, might no longer meet criteria for accommodations, because they (and their diagnostician) cannot articulate, or provide evidence of, actual functional limitations or barriers to access that the person faces. That is, test-takers who have the connections and financial resources to obtain impressive diagnostic evidence might no

longer able to enjoy a material advantage. On the other hand, adult test-takers who are disabled, and who might have been prevented from accessing accommodations due to the cost of obtaining medical or psychological diagnostic evidence, could have alternative means for providing supporting documentation from professionals who know them well and who can articulate their functional challenges.

Although it may take years, if ever, for many US-based certification and licensure organizations to dispense with the old medical model of disability and its associated documentation requirements, the authors believe that following the success of a handful of test programs that have adopted a more inclusive approach, others may follow.

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Appendix A

Example 1: Letter from an employer on business letterhead and signed by a manager:

[Applicant] has been an employee of [business] since [month, year]. He was originally set up in an open office space around two other individuals. During this time, he articulated his struggles with maintaining focus due to the amount of noise and movement in the environment. Our ultimate intervention was to both allow him to work a hybrid, work from home schedule, and while in the office, have him work in an empty, closed-off office. Since, his self-reported focus has strengthened concurrent with the speed and performance of his work.

Given the reasonable accommodations we have provided, [applicant] has demonstrated his ability to be a valuable employee of our firm. The same accommodations he was provided in undergraduate school and now in his work environment (isolated room either at home or at the testing facility) seem more than reasonable to perform well on the exam. We will continue to support his personal and professional growth any way we can.

Example 2: Letter from Human Resources (HR) on business letterhead and signed by the HR manager:

[Applicant] is an employee of [business] since [date]. We have documentation on file that meets the ADA requirements for accommodations related to [applicant's] ADHD diagnosis.

The following are examples of some of the workplace accommodations that have been extended to [applicant] at times during her employment.

- Additional time with trainers when learning about new equipment/programs.
- Access to manuals and troubleshooting material to review at a slower pace and write notes.
- Allow note taking or if/when allowed voice record teaching session to review later and create notes if teaching at a slower pace is not possible.
- Very low/quiet calm music allowed at workstation at appropriate times.

Example 3: Letter from a university faculty advisor/mentor/disability staff person signed and on university letterhead:

I have been a professor at [university name/college] since [provides basic information about experience]. I have taught and mentored many students during my career. [Additional information about author experience is helpful, but not necessary.] I first came to know Sophia as a student in my [name of class] course, and she subsequently took several more of my courses. She was always a very engaged student in our courses and always appeared to have a solid grasp of the material. However, she repeatedly asked for extensions on assignments, could not seem to meet deadlines in a timely manner, and submitted work late despite having the accommodation of a time extension. While Sophia's ability to submit timely work is a serious impediment, when she is allowed the additional time, her work is excellent. Indeed, given her skills, I have regularly contracted with her as an independent research assistant performing document review, conducting research, analyzing findings, and drafting research memoranda.

I have had regular interactions with Sophia over the course of the last three years. I can attest to her disabilities as significantly impacting her functioning. For example, she displays an extremely methodical approach to research assignments and tasks. To some degree this is beneficial; however, it can expand to a perseverative fixation of particular details. This inhibits her being able to completely answer research queries within a typical amount of time. Sophia requires two to three times as many hours to read and review materials as I would expect. She also engages in excessive re-writing and revision, which further inhibits her ability to meet timed deadlines of any sort, including that of work assignments or examinations.

While Sophia is clearly a bright individual, she appears to struggle to rapidly process her thoughts, and this appears to be exacerbated in stressful and time-restricted settings and in

environments with large groups of people. I have directly observed her increased discomfort, difficulty functioning, and distractibility when we have met in more crowded settings. Thus, in my professional opinion, and based on my personal knowledge of Sophia I do not believe that she would be able to have access to the exam in the same way as other typical individuals without having the disability accommodations of extended time and use of a private room.