

STATE OF NEW YORK – DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION

**REFERRAL FORM FOR ADULTS WITH LEARNING DIFFICULTIES WHO ARE REQUESTING ACCOMMODATIONS ON STANDARDIZED TESTING**

FACILITY: \_\_\_\_\_

TO: Name: \_\_\_\_\_  
(Education Supervisor or DSP if inmate is referring him/herself)

FROM: \_\_\_\_\_  
(Person making referral)

DATE: \_\_\_\_\_

INMATE'S NAME: \_\_\_\_\_ DIN: \_\_\_\_\_

Please indicate your reasons for believing this student has a difficulty:  
(If this is a self-referral, please state the reasons why you believe you have a learning difficulty)

List any test results, records, or reports upon which the referral is based:

Describe any prior attempts to remediate the inmate's performance or reasons why remediation was not attempted:

(Send the completed form to the Assistant Director of Academic Education with a copy to the DSP)