

FRM[®]

ADA FORM 2024

The Global Association of Risk Professionals (GARP) provides reasonable and appropriate testing accommodations for disabled candidates wishing to take the Financial Risk Manager (FRM®) Exam. GARP defines an “accommodation” as any modification in the standard administration of the Exam. A candidate requesting special accommodation must document the existence of a physical or mental impairment that significantly limits the candidate’s ability to perform a major life function, the current impact of the impairment, and how it affects the candidate’s ability to take the Exam under standard conditions, including a justification and unbiased objective of the requested accommodation.

THE PROCESS FOR REQUESTING SPECIAL ACCOMMODATIONS

1. Register for the FRM Exam.
2. Complete Section I: Candidate Information, and Section II Part I—Medical Verification by Candidate.
3. Complete Section II Part II—Medical Verification by Physician.

Please have a qualified physician or qualified/licensed professional who is familiar with the impact of your disability complete Part II of the form. Please submit along with supporting documentation.

Be sure that GARP receives the application and supporting documents together no later than the deadlines listed to the right.

Late or incomplete applications will not be considered.

4. Email your completed application to **ADA@garp.com**. You will receive confirmation of the receipt of your application via email shortly after the application deadlines listed to the right, at which point GARP will begin the review of your special accommodations application.
5. GARP will review your application to ensure the requested accommodations can be granted. Once the accommodations are approved, you will receive an email with an official confirmation letter no later than March 15, 2024 (May Exams), June 15, 2024 (August Exams), or September 15, 2024 (November Exams). If GARP cannot grant your request, you will be notified on or before this date, as well.
6. The formal confirmation of accommodations approval letter will contain instructions on how to schedule your exam with the approved accommodations. After approval please follow the instructions in the confirmation letter to schedule your exam before the scheduling deadline.

FRM Exam Application Deadlines

May 2024
Application Deadline:
February 28, 2024

August 2024
Application Deadline:
May 31, 2024

November 2024
Application Deadline:
August 31, 2024

Returning ADA Candidates

If you are a returning candidate for the FRM Exam and have previously submitted documentation, and it is not more than **two years old**, you are not required to resubmit the entire form again. However, upon registration, you will need to notify us via email (**ADA@garp.com**) of your request and only submit Section I of this application, as this will indicate which Exam you have registered for, and your requirements needed in order to sit for it. Please indicate in the subject heading: A second request for Special Accommodations for Americans (ADA).

Note: Candidates who do not need Special Accommodations for medical reasons do not need to complete the ADA form.

Section I

Candidate Information

GARP ID: _____

Exam Site/City: _____

Last name: _____ First name: _____ Middle initial: _____

Candidate email address: _____

Please indicate the Exam for which you have registered:

FRM Part I

May 11, 2024 - May 17, 2024

August 9 - 10, 2024

November 9, 2024 - November 15, 2024

FRM Part II

May 18, 2024 - May 22, 2024

August 9 - 10, 2024

November 16, 2024 - November 19, 2024

Are you a returning candidate? **Yes** **No**

If yes, briefly describe the accommodations granted to you, if any.

Nature of Disability

(please indicate all that apply)

AD/HD
Cognitive or Learning Disability
Hearing Disability
Physical Disability
Psychological Disability
Visual Disability
Other

Accommodations Requested

(please circle those that apply)

Additional time
Assistance for visually impaired
Consumption of food and/or drink
Large print Exam (please indicate font size)
Scribe
Semi-private room/distraction reduced environment
Wheelchair access
Other

Note: Accommodations must be appropriate to the disability and supported by documentation.

Please describe in detail the type of accommodations requested:

If requesting special equipment or personal items in the testing room (e.g., medications, special chair, special lighting), please describe:

If you are requesting additional time, please indicate the amount of time needed per session as supported by documentation. (Each Exam session is 110 minutes.)

FRM Exam Part I: _____ **FRM Exam Part II:** _____

Candidate Acknowledgment

I declare that the person completing the written report is a qualified professional who has diagnosed and/or treated me for the disability for which I am seeking an accommodation.

I agree to notify GARP of any material changes in my condition. I understand that any false or misleading information I give in connection with this test may subject me to discipline in accordance with the GARP Code of Conduct, which could include the suspension or termination of my candidacy or right to use the FRM designation.

I understand that this request may be reviewed by a qualified professional retained by GARP to assist in evaluating or implementing requests for testing accommodations. I further understand that documentation submitted must be current or updated within the last two years. If documentation is determined by GARP to be insufficient or not current, I understand that I may be required to submit additional or more current information.

I understand that I may not be granted an accommodation by GARP.

I declare that all information I have supplied in connection with this examination is truthful and complete.

Candidate Signature: _____ Date: _____

Section II

Medical Verification

Candidates requesting accommodations based on disability must provide professional documentation from all evaluations. Please attach all relevant documentation detailing a history of significant impairment.

The evaluation must:

- Be conducted by a qualified professional who is familiar with the impact of the candidate's disability on his or her ability to perform on the FRM Exam or other similar timed standardized tests;
- Have been completed or updated within the last two years;
- Provide an explanation of differential diagnosis and an evaluation of current impact of the candidate's disability on his or her ability to perform on the FRM Exam or other similar times standardized tests;
- Provide data-based evidence of significant impairment in the area for which an accommodation is requested;
- Provide evidence that this diagnosis does not rely solely on self-report in establishing developmental history, current symptoms, and evidence of clinically significant impairment.

PART I - MEDICAL VERIFICATION (To be completed by candidate)

Candidate last name: _____ **First name:** _____

Please provide a description of your disability and the extent of its effect on your daily life activities.

Use separate sheets, if necessary.

Please describe how the condition affects your ability to take the FRM Exam, and explain why you need the accommodations requested. Use separate sheets, if necessary.

PAST DISABILITY ACCOMMODATIONS RECEIVED

Yes **No** Did you receive formal disability accommodations in high school?
If yes, please describe the disability accommodations you received:

Yes **No** Did you receive formal disability accommodations in college or university?
If yes, please describe the disability accommodations you received:

If you answered "yes" to either of the above questions, please attach any records or other documentation concerning the diagnosis and the disability accommodations granted, include past professional evaluations and/or educational records.

Yes **No** Have you ever taken the SATs, ACTs, GREs, CFA, or other professional/entrance-type examinations?

Yes **No** If yes, have you ever requested disability accommodations for the SATs, ACTs, GREs, CFA or other professional/
N/A entrance-type examinations? If yes, please indicate whether your request was granted and specify the
accommodations granted:

Yes **No** Has the documentation that you are submitting been completed or updated in the last two years?

Note: Two years is defined as two years from December 31 or the year the documentation has been completed or updated. For example, documentation completed or updated any time during 2024 would be valid through December 31, 2026.

I, _____, certify that all information on this form is true and correct. **(Candidate: please print your name)**

Candidate Signature: _____ **Date:** _____

PART II - MEDICAL VERIFICATION (To be completed by a physician or qualified/licensed professional)

This form must be completed by a qualified/licensed medical evaluator who is familiar with the candidate's condition and its impact on the candidate's ability to perform on the FRM Exam. Please reference specific tests, clinical observations, and other objective data and attach relevant documentation. Please type directly on this form (in English) or print legibly.

Physician or qualified/license professional name: _____

Title: _____

Phone number: _____

Email: _____

DIAGNOSIS (Provide a diagnosis): _____

Date the candidate was first diagnosed: _____ (mm/dd/yyyy)

Date of your most recent diagnosis of the candidate's disability: _____ (mm/dd/yyyy)

EVALUATION

How does the condition or disability affect the candidate's ability to perform on the FRM Exam?

Yes	No	Does any objective testing you performed on the candidate suggest a need for special accommodation(s)?
		Please explain:

RECOMMENDATION

Please indicate the testing accommodations you recommend:

Additional time
Assistance for visually impaired
Consumption of food and or drink
Large print examination (please indicate what font size) _____
Scribe
Semi-private room/distracted reduced environment
Wheelchair access
Other:

Please explain your rationale for the requested accommodations:

I, _____, certify that all the information on this form is true and correct to the best of my knowledge and belief. I understand that this information may be reviewed by a qualified professional retained by GARP to assist in evaluating or implementing requests for testing accommodations.

Physician/Qualified Licensed Professional Signature: _____ **Date:** _____

License/Certified Number: _____



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ABOUT GARP | The Global Association of Risk Professionals is a non-partisan, not-for-profit membership organization focused on elevating the practice of risk management. GARP offers the leading global certification for risk managers in the Financial Risk Manager (FRM®), as well as the Sustainability and Climate Risk (SCR®) Certificate and ongoing educational opportunities through Continuing Professional Development. Through the GARP Benchmarking Initiative (GBI)® and GARP Risk Institute, GARP sponsors research in risk management and promotes collaboration among practitioners, academics, and regulators.

Founded in 1996 and governed by a Board of Trustees, GARP is headquartered in Jersey City, N.J., with offices in London and Hong Kong.

For more information, visit garp.org or follow GARP on [LinkedIn](#) [Facebook](#), and [X \(formerly Twitter\)](#).

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