Eligibility Form for Students Needing Extended Testing Time

This form must be received at one of the following offices by October 20, 2026: No Exceptions

Archdiocese of Newark: (Counties of Bergen, Essex, Hudson, Union, NJ, or Rockland Co., NY)
Schools Office-COOP, P.O. Box 9500, 171 Clifton Avenue, Newark, NJ 07104-0500

Diocese of Paterson: (Counties of Morris, Passaic, or Sussex, NJ)
COOP Coordinator, 205 Madison Avenue, Madison, NJ 07940

STUDENT NAME (Print) | **BIRTH DATE**

Last	First	MI	M M D D Y Y

MAILING ADDRESS | **TELEPHONE NUMBER**

Number, Street, Apt./Floor	City	State	ZIP	Area Code	Number

E-Mail:

CURRENT ELEMENTARY SCHOOL | **GENDER**

School Name	School Code (if not a participating school write "999")	☐ M ☐ F

ELIGIBILITY:

What qualifies the student for extended testing time? (check one)

☐ The extended testing time accommodation is prescribed in the student's attached IEP/ISP/504/A6044.

☐ Temporary (describe): _____

What type of documentation are you providing to support the request for extended time? (check one)

☐ Current IEP/ISP/504/A6044 **(Within past three years).** Submit the cover page showing the student's name, birthdate and date of evaluation/re-evaluation **and** the page stating the accommodation of additional time for testing

☐ Summary of an evaluation by a qualified medical/psychological professional indicating the need for additional time for testing **(Within past two years)**

This application will not be processed if required documentation is not submitted.

Parent Agreement:

I, the undersigned, agree that the above information is correct and that the above-mentioned student is eligible to apply for extended testing time for the 2026-2027 Cooperative Admission Program HSPT. **A copy of the required documentation is attached.**

Parent's or Legal Guardian's Signature | **Date**

DO NOT RETURN THIS FORM TO NJCOOPEXAM OR STS. RETURN TO THE ADDRESS AT TOP OF FORM.
IN ADDITION TO SUBMITTING THIS FORM, YOU MUST REGISTER FOR THE HSPT TEST AT WWW.NJCOOPEXAM.ORG