

Documentation Guidelines for Test Takers with Traumatic Brain Injury

Office of Disability Policy
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I. Preface

ETS recognizes the importance of periodic review of documentation guidelines to ensure that they reflect current practice and professional standards, developments in the field and recent guidance from the Department of Justice. This edition (2026) of the ETS Documentation Guidelines for Test Takers with Traumatic Brain Injury incorporates the previous edition and introduces other changes based upon many years of experience with test takers with traumatic brain injury (TBI).

II. Introduction

ETS is committed to providing reasonable testing accommodations for test takers with documented disabilities as recognized under the ADA Amendments Act of 2008 (ADAAA). We review requests for accommodations on a case-by-case basis according to established policies and practices, which ensure that people with disabilities have equal access to ETS tests. This document provides guidance to test takers with TBI who are requesting accommodations. It also provides guidance to evaluators regarding the documentation of TBI and the linking of accommodation requests to disability-related functional limitations.

You may refer to <https://www.ets.org/disabilities/test-takers.html> for helpful information on requesting accommodations, registering for a test and scheduling a test date. You can also use the “For Test Takers” page for a list of common accommodations, information on where to find bulletins for the test(s) you plan to take, how to determine if documentation is needed to support requested accommodations, and how to register, pay for and schedule the test(s).

To provide more information for your evaluators or other relevant professionals, please direct them to <https://www.ets.org/disabilities/evaluators.html>.

Definitions

Acquired Brain Injury:

According to the Brain Injury Association of America (2024), an acquired brain injury “is an injury to the brain...that has occurred after birth”, i.e., it “is not hereditary congenital, degenerative, or caused by birth trauma.” Acquired brain injuries may be categorized as traumatic and non-traumatic. Traumatic brain injuries include injuries caused by falls, assaults, motor vehicle accidents, sports injuries, etc. Non-traumatic brain injuries are typically caused by factors internal to the body and may include stroke, hypoxia (i.e., oxygen loss), aneurysm, tumor, and infectious diseases (i.e., meningitis, encephalitis, etc.). Although these guidelines focus primarily upon traumatic brain injuries, they may also be applied to all acquired brain injuries, including those that are non-traumatic.

Traumatic Brain Injury:

A traumatic brain injury (TBI) involves a disruption of normal brain function as a result of exposure to an external physical force. The trauma may be direct or indirect. A direct TBI involves impact from an object striking the head or the head striking an object. However,

damage to the brain can be indirect, as when the rest of the body is suddenly subjected to acceleration or deceleration or to the shock wave from an intense explosion. TBIs may have mild to profound effects on physical, psychological, emotional, and/or social functioning. They are classified in multiple ways. A primary injury refers to damage that immediately results from the trauma; it may involve bruises and bleeding in the brain itself or damage to surrounding structures. This primary event can set in motion a series of molecular responses that can lead to further damage, through changes in membrane activity, release of neurotransmitters, oxygen deprivation, swelling, increased pressure inside the skull, etc. TBIs can also be further classified by type (open vs. closed; uncomplicated vs. complicated) and severity.

Concussion:

Concussion is a clinical subset accounting for an estimated 75 to 90 percent of traumatic brain injuries. In the United States, the term is often used interchangeably with Mild Traumatic Brain Injury (mTBI). Six key elements characterize concussion: (1) it is a complex pathophysiological process; (2) it results in the rapid onset of neurological impairment that typically resolves spontaneously although not always; (3) loss of consciousness and amnesia may or may not occur; (4) brain imaging (e.g., CT scan, MRI) typically fails to show evidence of structural abnormality, and brain dysfunction in concussion is usually related to problems with brain metabolism rather than structural damage or injury; (5) multiple domains are often affected in its aftermath (i.e., physical, behavioral, cognitive, sleep disturbances, etc.); and (6) clinical presentation varies substantially across individuals.

Post Concussive Syndrome (PCS):

Post-concussive or post-concussion syndrome is a set of symptoms that may continue for weeks, months, or occasionally a year or more after a concussion. Common features include headache, dizziness, irritability, diminished concentration, sleep disturbance, and intolerance to stimulation (e.g., lights or sound).

Cumulative Head Trauma:

Cumulative Traumatic Encephalopathy (CTE) refers to the damage caused by repeated TBIs or mTBIs/concussions. It is a newer clinical entity which is characterized by a progressive deterioration of functioning as reflected in mood and personality changes and ultimately resulting in global dementia. Professional athletes and military personnel who have experienced active combat appear to be at elevated risk for this syndrome. Like many progressive neurological conditions, diagnosis of CTE poses challenges and it can only be diagnosed post-mortem. However, for research purposes, expert consensus has been reached regarding “diagnostic criteria for Traumatic Encephalopathy Syndrome (TES), the clinical disorder associated with neuropathologically diagnosed Chronic Traumatic Encephalopathy (CTE)” (Katz et al., 2021, p. 848).

Blast Trauma:

Blast Trauma occurs when the human body is subjected to intense pressure emanating from explosions. This injury has been seen extensively in military service members returning from the Middle East who have been exposed to blasts from improvised explosive devices (i.e., IEDs) and rocket-propelled grenades.

Second Impact Syndrome:

Second Impact Syndrome (SIS), also known as repetitive head injury syndrome (May et al., 2023), refers to a dire clinical situation in which an individual with an unresolved TBI experiences a second — sometimes seemingly minor — brain injury hours or days later, and then suffers life-threatening or fatal complications. It is thought that the underlying molecular alterations resulting from the initial injury make the brain highly vulnerable to further damage for a narrow window of time. Preventing this syndrome is one of the main objectives of the “return to play” restrictions in athletics following TBI.

III. Documentation Details

Who should conduct an evaluation and what identifying information is important?

A qualified and licensed professional, with demonstrated training and experience in the assessment of TBIs in adolescents and adults, should conduct the evaluation. Such professionals may include (but are not limited to): physician (i.e., neurologist, physiatrist, developmental pediatrician, primary care physician), nurse practitioner, physician’s assistant, neuropsychologist, clinical psychologist, school psychologist, psychiatrist, occupational therapist, physical therapist, speech and language pathologist, optometrist or other comparable professional. While not required, a multi-disciplinary assessment approach may also be appropriate. Consistent with professional standards and ethics, it is typically not appropriate for professionals to evaluate members of their own families, close friends, or members of a close friend’s family.

The name, title and professional credentials of the evaluator should be clearly stated in the documentation. This information should include licensure and/or certification, as well as the areas of specialization, employment and the state or province in which the individual practices. Evaluations conducted by tele-assessment or via a hybrid of tele-assessment and in-person assessment should indicate which parts of the evaluation were conducted in person and which parts were conducted remotely. Remote assessments should state the geographic location(s) of the evaluator and the test taker at the time of evaluation. For additional information, please see ETS Tele-Assessment Guidance, <https://www.ets.org/pdfs/disabilities/tele-assessment-guidance.pdf>. All reports should be on letterhead, typed in English, dated, signed and otherwise readable.

How recent should documentation be?

Recovery from TBI is an evolving, dynamic process, with wide variability in its timing and completeness across individuals. If an injury is in the mild range, a stable endpoint is typically achieved within approximately three months. In moderate to severe TBIs, the recovery process can continue for many months or years. It is also possible for secondary complications such as seizures or mood dysfunction to arise well after the initial event. Additionally, intervening events or later treatments for TBI (e.g., medications) may lead to further problems.

In order for a determination to be made regarding reasonable accommodations, documentation should verify the functional impact of the disability as it relates to the current test-taking situation. Since further recovery can occur, the applicant's accommodation needs are not necessarily permanent as of the date of the evaluation. The submitted functional profile should reflect the test taker's disability-related functional limitations in a time frame that is relevant to the anticipated standardized test administration. Consequently, the time frame of the documentation is another factor that ETS will take into consideration. If the traumatic brain injury occurred within the last year, documentation from the past 12 months is helpful. For test takers with a date of injury exceeding one year ago, documentation from within the past 3 years is helpful.

What should be included in an evaluation?

A. Sources of Information

A list or brief narrative paragraph of all sources of information used in the evaluation. This includes but is not limited to: records personally reviewed by the evaluator (i.e., medical records, prior evaluation reports, standardized test results, IEPs, Section 504 plans, employer performance reviews, school transcripts, etc.); and information from third-party informants who were either interviewed or completed questionnaires, inventories, etc.

B. A Summary of a Clinical Interview and Behavioral Observations Including

A history of presenting problems associated with the disability as well as information about the test taker's relevant medical, developmental, educational, vocational and family history; a discussion of pre-existing or co-existing conditions (i.e., behavioral, medical, neurological, psychiatric, etc.); any history of medication use that may affect the individual in the current testing situation; the date and cause/circumstances of the injury; hospitalization/rehabilitation dates; and duration and severity of the disorder. Per "sources of information" above, a combination of applicant self-report, interviews with others (i.e., third-party or collateral informants) and review of prior medical information and/or psychometric assessment is helpful -- as is a qualitative description and behavioral examples of the applicant's test behaviors and strategies used in the testing process. This description may include signs of anxiety, fatigue and/or motivational issues, etc.

C. Psychometric Assessment and Objective Data

- Objective data in the evaluation, which reflects disability-related functional limitations that impact learning and/or test taking — or which impact the test taker in the assessment situation. Assessment should consist of a suitably comprehensive, individualized, standardized, and norm-appropriate battery that reflects the functional limitations associated with the requested accommodations. The choice of the psychometric assessment battery should be guided by the overall objective(s) of the evaluation, the individual needs of the test taker, sound clinical judgment and prevailing professional practices.

- Domains assessed in a TBI evaluation will vary depending upon the type and extent of the injury. They may include some or all of the following areas as relevant: overall cognitive abilities, verbal reasoning, nonverbal reasoning, memory, attention/alertness, speed of processing/thinking, communication/language (i.e., including communication pragmatics), perceptual organization, spatial reasoning, conceptualization, executive functioning, psychological adjustment and psychosocial behaviors, motor, sensory or physical abilities, and academic achievement. Neuropsychological screening and monitoring measures may also be used.
- Tests that are reliable, valid, and standardized for use with an adolescent/adult population; and, whenever possible and appropriate, the most recently normed edition of the test should be used. In rare instances, it is clinically acceptable to use a previous edition of a test or a test with a norm group that does not align with the test taker's age, grade, etc. When a previous edition of the test is used or when "out-of-norm" testing is clinically indicated, the evaluator should explicitly state this in the narrative and should provide a clinical rationale for why this choice was made. The test findings should document both the nature and severity of the TBI.
- Informal inventories, surveys and direct observation by a qualified professional may be used along with formal tests and often help to provide a clearer understanding of the test taker.
- Standard scores and/or percentile ranks for all measures administered (i.e., composite scores and subtests). The data should reflect and directly link a substantial limitation to learning for which the test taker is requesting the accommodation. The particular profile of the test taker's strengths and weaknesses should be directly linked to functional limitations that necessitate accommodations (i.e., accommodations are determined based on functional limitations associated with a diagnosis, not based on the diagnosis itself). In addition to scores reported in the evaluation narrative, a score table(s) of standard scores and/or percentile ranks for all measures administered (i.e., composite scores and subtests) is recommended.

D. A Clear Diagnosis and Statement of Disability (i.e., functional limitations)

- A clear diagnostic statement, in accordance with the most recent edition of the DSM or ICD, and a discussion of functional limitations related to the TBI. The evaluation should describe both the nature and severity of the TBI. The evaluator should also describe the impact that TBI has on major life activities across multiple domains (e.g., school, employment, interpersonal relationships, etc.) including the significance of this impact on the individual's learning and test taking in particular.
- Rule outs. It is important to rule out alternative explanations for problems in learning, such as emotional, psychiatric, attentional, medical, situational or motivational factors in addition to medication effects that may be interfering with learning but are not related to the TBI. If the clinical and objective data do not support the presence of TBI-related functional limitations, the evaluator should state that conclusion in the report.

E. A Rationale for Each Accommodation Recommended by the Evaluator

- A direct link should be established between each requested accommodation and the individual's functional limitations as they apply to the current testing situation. Qualified professionals should be clear and specific with the disability driven rationale for the requested accommodation(s).
- A diagnosis in and of itself is not necessarily a disability and does not automatically warrant approval of requested accommodations. Linking the diagnosis to disability-related functional limitations is important and helpful in determining reasonable accommodations.
- In the case of TBI-related conditions that can cause periodic or waxing and waning symptoms (e.g., epilepsy, migraine, depression, panic attacks, etc.), it is helpful for clinicians to explain how the frequency and severity of such associated problems relate to the need for the recommended accommodations. For example, although a previously sustained concussion may cause an individual to suffer occasional headaches, the mere potential for a headache during standardized testing may not in itself warrant the provision of accommodations. Information about frequency, intensity and severity of symptoms provides helpful clarification.
- With regard to accommodation recommendations, it is helpful for the qualified professional to make a distinction between on-the-clock extended testing time in contrast to stop-the-clock breaks. Extended testing time tends to be appropriate for examinees whose functional limitations cause them to work more slowly on actual test content. Stop-the-clock breaks is typically a more appropriate accommodation for examinees who need additional off-the-clock rest time or who require breaks to address their medical needs (e.g., taking medication, using the restroom, enacting relaxation techniques, etc.).
- ETS gives considerable weight to a prior history of accommodations. Since recovery from TBI is dynamic and evolving, however, a prior accommodation history does not automatically warrant accommodation approval; nor does lack of prior accommodation history warrant non-approval of accommodations. Accommodations are meant to address disability-related functional limitations as they apply to the current testing situation. If there is no prior history of accommodations, it is very helpful for the evaluator and/or the test taker to include a clear explanation of why accommodations were not needed in the past as well as why they are currently needed.

F. An Interpretive Summary

Some of the sequelae of a TBI and their related functional limitations are not easily captured in test scores. Therefore, the interpretive summary of an evaluation report should also highlight clinical data and observations that go beyond test scores. It should convey a sense of how the individual's TBI-related functional limitations impact the way that they interact with their environment. This should not only include a focus on academic performance in a testing situation. Equally important, it should also address how their functional limitations may impact their ability to navigate the multiple demands of a test taking situation (e.g., sensory, social, ability to deal with unexpected changes that may arise, etc.). Generally, an interpretive summary should include:

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- A well-written narrative that integrates objective data with the current reason for referral, the test taker's history (i.e., including records reviewed and information from third party informants) and behavioral observations of the test taker during the evaluation to support a diagnostic formulation. The diagnosis and interpretive summary require professional judgment and should address:
 - how patterns in clinical and objective data are used to determine the test taker's TBI-related functional limitations;
 - the specific and substantial limitations to learning and/or test-taking behavior presented by the TBI and how they affect the individual in the testing context for which accommodations are being requested; and
 - why specific accommodations are needed on the test and how disability-related functional limitations are addressed by the recommended accommodations.
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What if the submitted documentation is insufficient for current accommodation determination?

If the submitted documentation does not provide sufficient information for current accommodation determination, a re-evaluation or a documentation update may be submitted.

A documentation update for TBI is a brief report or narrative by a qualified professional that includes a summary of the previous disability documentation findings as well as additional clinical and observational data to establish the test taker's need for the requested testing accommodations. Observational data gathered during the recent clinical interview, including affect, concentration, attention, mental stamina, social reciprocity, language pragmatics, executive functioning, sensory integration and personal hygiene may be helpful. The updated evaluation need not include a full battery of tests. However, it should include selected measures deemed appropriate — along with academic measures — to support and directly link disability-related functional limitations with requested accommodations.

In addition to documentation from a professional, any information from the applicant that helps to clarify and/or illustrate the need for the requested accommodation(s) in the current testing situation is also welcome. This might include a personal statement from the test taker that explains how their disability affects learning, test taking and performance.

The following are general recommendations for information to provide in a documentation update:

- a restatement of the current diagnosis accompanied by supporting documentation, if available, including date(s) for all prior diagnoses and data that were used to establish the diagnosis;

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- verification of continuing weaknesses in those areas identified in prior evaluation(s);
 - a statement from a professional who has worked with the test taker about how the test taker's functional limitations may impact the current test-taking situation;
 - observational data from the test taker's clinician, a disability service professional and/or a work supervisor regarding relevant behaviors such as ease of work production, test taking and/or the general impact of the TBI;
 - a history of the accommodations the test taker has received and the consistency and circumstances of their use (e.g., type of test for which accommodations have been most helpful), or an explanation of why accommodations have not been used previously but are needed now; and
 - a discussion of the appropriateness of the requested accommodations for the specific ETS test which the test taker is applying to take.
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When is a documentation update particularly helpful?

No exact combination of factors ultimately determines whether a more in-depth reevaluation or documentation update would be the most appropriate documentation to submit. The following factors should be considered by test takers and the professionals with whom they work to make this determination:

- the test taker's age at the time of first diagnosis and the consistency of the test taker's functional limitations over time;
- the number of previous evaluations which include appropriate measures and methods;
- the availability of documentation from educational institutions, workplaces or testing agencies confirming the prior use of accommodations;
- the presence of pre-morbid, co-occurring or co-morbid disorders that interact or compound the TBI; and
- the clinician's ability to address the above listed essentials of documentation update effectively without additional evaluation (i.e., a statement of why a more in-depth evaluation or "testing" would be otherwise redundant or burdensome).

Multiple Diagnoses

Multiple diagnoses may require a variety of accommodations beyond those typically associated with the functional impact of a single diagnosis. When accommodations are requested by a test taker with multiple diagnoses (e.g., a TBI with an accompanying psychological disability, etc.), it may be sufficient in some instances to provide documentation for either disability category (i.e., psychiatric disorder or TBI). However, in other instances, documentation for both disability categories will be most helpful in order to provide a sufficient understanding of the test taker's functional limitations in relation to the current testing situation. Clinicians may find it helpful to consult ETS's policies and guidelines for documentation. If the accommodations requested are not supported by the current documentation and multiple diagnoses are suspected, the clinician should recommend/refer the individual to another appropriate qualified professional for additional assessment.

IV. Conclusion

ETS is committed to providing equal access to our assessments for all test takers. If you have been diagnosed with TBI and believe you need accommodations for equal access during the standardized testing process, ETS will review the information you provide and will work with you to identify any additional documents that will be helpful to make a timely determination regarding your request for reasonable accommodations. We welcome the opportunity to engage in discussions with test takers who have disabilities to determine reasonable accommodations on a case-by-case basis.



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