



**APPLICATION FOR CANDIDATES REQUESTING
SPECIAL TESTING ACCOMMODATIONS
IN ACCORDANCE WITH THE
AMERICANS WITH DISABILITIES ACT**

Prior to completing the application, we strongly recommend that you carefully read the requirements under Rule 64B-1.005, Florida Administrative Code (F.A.C.) for requesting special testing accommodations in accordance with the Americans with Disabilities Act (ADA). You must know and comply with the rules as they pertain to your request. For updated information on the F.A.C. refer to the following website: www.flrules.org.

This application has two parts. Part I is to be completed by the candidate seeking special accommodations in accordance with the ADA. Part II is to be completed by a qualified health care practitioner.

Required Documentation:

PART I – Application instructions to be completed by the candidate requesting special testing accommodations

Personal Statement

PART II – Application instructions to be completed by a Florida licensed health care practitioner requesting special testing accommodations

Supporting Clinical Documentation from a qualified health care practitioner

Mailing information:

Required documentation may be submitted to mqa.specialtesting@flhealth.gov or may be sent to the following address:

Department of Health
Division of Medical Quality Assurance
ATTENTION: ADA Accommodations
4052 Bald Cypress Way, Bin # C-91
Tallahassee, FL 32399-3250

Note: Do not send your request for special testing accommodations application to the board office. Do not mail your application for licensure or examination to this address because this will delay action on your application.

PART I – APPLICATION INSTRUCTIONS TO BE COMPLETED BY THE CANDIDATE REQUESTING SPECIAL TESTING ACCOMMODATIONS

Instructions:

- A. Who Should File the Application:** The Candidate seeking special testing accommodation for an ADA disability should complete Part I.
- B. Application Submission Deadline:** Completed applications should be submitted at least 60 days prior to the examination for which you are requesting special testing accommodations. If submitted with less than 60 days until the examination, the department will provide any requested accommodation that can be made available without posing undue burden or jeopardizing the security and integrity of the examination. If a candidate who requires an accommodation fails to timely request such, then the candidate must select a later examination date.
- Required Documentation:** Applications must be supported by medical records documenting the disability. Documentation may include a copy of treatment or evaluation records, or a summary letter, that includes signs, symptoms, and clinical descriptions affirming your diagnosis and the functional limitations imposed by your condition. Please refer to the Special Testing Accommodations for Examinees with Disabilities instruction booklet for more information about documenting disabilities under the ADA. Documentation must be from a qualified professional appropriate for evaluating the disability, **pursuant to Chapters 490 (Psychological Services), 458 (Medical Practice), 459 (Osteopathy), 461 (Podiatry), 463 (Optometry), or 468, Part I (Speech Language Pathology & Audiology), Florida Statutes**, or by a practitioner in one of the above listed fields who is licensed in a comparable jurisdiction.
- C. Review:** A review of each application will be completed after each submission. The department will defer the review of each application until all necessary documentation is completed and submitted.
- D. Type or Print All Information on the Application.** Do not leave sections blank, insert “N/A” if the section does not apply.
- E. Confidentiality:** To protect confidentiality, always send special testing accommodation information **separately to the address below. Do not include these materials with an examination application.** All materials received related to special testing accommodations will be held in confidence.
- F. Mailing information:**
Submit your application and any supplemental documentation you are sending with your application via email to mqa.specialtesting@flhealth.gov or to the following address:

Department of Health
Division of Medical Quality Assurance
ATTENTION: ADA Accommodations
4052 Bald Cypress Way, Bin # C-91
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**PART I - APPLICATION FOR CANDIDATES REQUESTING
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SECTION 1: PERSONAL DATA

1. Name: _____
 First Middle Last

Date of Birth: _____
 Month Day Year

2. Mailing Address: _____
 Street Apt. Number

_____ City State ZIP Code

_____ Email Address

3. Phone Number: (____) _____ (Mobile) (____) _____ (Work)

4. Email Address: _____

SECTION 2: EXAMINATION FOR WHICH ACCOMMODATION IS REQUESTED

1. Profession: _____

2. Month / Year of Exam: _____

3. Name of the Examination (check all those that pertain and identify by name):

___ (1) Laws and Rules

___ (2) National

 ___ (a) Practical _____

 ___ (b) Written _____

 ___ (c) Specialty(ies) (if applicable): _____

___ (3) State Exam

___ (a) Practical _____
___ (b) Written _____
___ (c) Specialt (ies) (if applicable): _____

___ (4) Other (explain): _____

SECTION 3: NATURE OF REQUEST

1. Please select the nature of your request:

- | | |
|---|--|
| <input type="checkbox"/> Chronic Health Problem | <input type="checkbox"/> Temporary Accidental Injury |
| <input type="checkbox"/> Hearing Disability | <input type="checkbox"/> Visual Disability |
| <input type="checkbox"/> Learning Disability | <input type="checkbox"/> ADHD/ ADD |
| <input type="checkbox"/> Physical Disability | <input type="checkbox"/> Other: _____ |

2. Do you require wheelchair access at the examination site?

- Yes No

SECTION 4: ACCOMMODATION(S) REQUESTED

1. Separately list each accommodation requested. Name your disability(ies) that require(s) this accommodation:

SECTION 5: PERSONAL STATEMENT

1. In order to document your need for accommodation, please attach a personal statement describing your disability and its impact on your daily life and educational functioning.

SECTION 6: LENGTH OF TIME WITH THE DISABILITY AND PRIOR ACCOMMODATION

1. How long ago was your disability first professionally diagnosed?

- Less than 1 year 1-2 years 2-4 years 5 or more years

2. Check any prior classroom or test accommodation(s) that you have received:

(a) Secondary or elementary school: Yes No
Accommodation(s) received: _____
(If extra time, note the amount given): _____

(b) College (if applicable): Yes No
Accommodation(s) received: _____
(If extra time, note the amount given): _____

(c) Other:
Year: _____
Accommodation(s) received: _____
(If extra time, note the amount given): _____

SECTION 7: CERTIFICATION / AUTHORIZATION

I certify that the above information is true and accurate. If the test accommodations granted to me include a deviation from the standard testing time schedule, I agree that, from the time I begin the examination until I have completed it, I will not communicate in any way, to the extent possible, with any other individuals taking the examination and I will not communicate in any way with any such individuals about the content of the examination.

Signature: _____

Date: _____

I understand the Department of Health will use the information obtained by this authorization to determine eligibility for a reasonable accommodation in regard to this examination by reason of my disability. This information will remain confidential pursuant to the provisions in Section 456.014, Florida Statutes. If clarification or further information regarding the documentation provided is needed, I authorize the Department of Health authority to contact the professional(s) who diagnosed the disability and/or those entities to communicate with the Department of Health in this regard to provide the Department with such clarification and/or further information.

Signature: _____

Date: _____

PART II – APPLICATION INSTRUCTIONS TO BE COMPLETED BY A FLORIDA LICENSED HEALTH CARE PRACTITIONER REQUESTING SPECIAL TESTING ACCOMMODATIONS

Instructions:

- A. Who Should File the Application:** A Florida licensed health care practitioner should complete Part II for a candidate seeking special testing accommodation for an ADA disability.

Documentation must be from a qualified professional appropriate for evaluating the disability, **pursuant to Chapters 490 (Psychological Services), 458 (Medical Practice), 459 (Osteopathy), 461 (Podiatry), 463 (Optometry), or 468, Part I (Speech Language Pathology & Audiology), Florida Statutes.** Documentation of the disability by a practitioner in the same field from another state may be made if the practitioner is licensed in that state and practicing the profession at the time the diagnosis was made.

If you are not a Psychologist, Medical Physician, Osteopathic Physician, Podiatrist, Optometrist, or licensed to practice Speech and Language Pathology and Audiology, **do not complete this form.**

Professionals conducting assessments and rendering diagnoses of learning disabilities must be qualified to do so. Comprehensive training in the differential diagnosis of various learning disabilities is required. The evaluator should provide professional credentials, including information about licensure or certification, the area of specialization and employment. Please designate the state where practicing.

- B. Application Submission Deadline:** Completed applications should be submitted at least 60 days prior to the examination for which you are requesting special testing accommodations. If submitted with less than sixty (60) days until the examination, then accommodations may not be provided.
- C. Required Documentation:** Applications must be supported by medical records documenting the disability. Documentation may include a copy of treatment or evaluation records, or a summary letter, that includes signs, symptoms, and clinical descriptions affirming your diagnosis and the functional limitations imposed by your condition. Please refer to the Special Testing Accommodations for Examinees with Disabilities instruction booklet for more information about documenting disabilities under the ADA.

PART II – Application instructions to be completed by a Florida licensed health care practitioner requesting special testing accommodations

Supporting Clinical Documentation from a qualified health care practitioner

- D. Review:** A review of each application will be completed after each submission. The department will defer the review of each application until all necessary documentation is completed and submitted.

- E. Type or Print All Information on the Application.** Do not leave sections blank, insert “N/A” if the section does not apply.
- F. Confidentiality:** To protect confidentiality, always send special testing accommodation information **separately to the address below. Do not include these materials with an examination application.** All materials received related to special testing accommodations will be held in confidence.
- G. Mailing information:**
Submit your application and any supplemental documentation you are sending with your application via email to mqa.specialtesting@flhealth.gov or to the following address:

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ATTENTION: ADA Accommodations
4052 Bald Cypress Way, Bin # C-91
Tallahassee, FL 32399-3250

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**PART II - APPLICATION FOR CANDIDATES REQUESTING
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SECTION 1: PRACTITIONER DATA

1. Practitioner Name: _____
First Last MI

2. Profession: _____

3. Specialty: _____

4. Certification: _____

5. Florida License Number: _____
 Other License Number (Include State): _____

6. Practice Location: _____
Facility Name

Street Apt. Number

City State Zip Code

7. Phone Number: (____) _____ (Mobile) (____) _____ (Work)

SECTION 2: PATIENT DATA

1. Patient Name: _____
First Last MI

2. Patient Profession: _____

<p>3. Date Patient First Consulted: _____ <div style="text-align: right;">(Month / Date / Year)</div> </p>
<p>4. Date Patient Last Seen: _____ <div style="text-align: right;">(Month / Date / Year)</div> </p>
<p>5. Diagnosis of Disability: _____</p>
<p>6. Name of Test(s) or Procedures Used to Diagnose the Disability:</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>7. Length of Time with the Condition: _____</p>
<p>8. Recommended Accommodation for Testing:</p> <p>_____</p> <p>_____</p>
<p>9. Reason that the Recommended Accommodations are Needed:</p> <p>_____</p> <p>_____</p> <p>_____</p>
SECTION 3: SUPPORTING DOCUMENTATION
<p>1. Applications must be supported by medical records documenting the disability. Documentation may include a copy of treatment or evaluation records, or a summary letter, that includes signs, symptoms, and clinical descriptions affirming your diagnosis and the functional limitations imposed by the patient’s condition. Please refer to the Special Testing Accommodations for Examinees with Disabilities instruction booklet for more information about documenting disabilities under the ADA.</p>

SECTION 4: CERTIFICATION

I hereby certify that the above information is true and is given pursuant to the authorization to release information by my patient. I declare that the foregoing statements and those in required accompanying documents or statements are true. I understand that pursuant to section 456.067, Florida Statutes, the act of giving false information may be cause for loss of a license or denial of possible licensure. I hereby certify that I personally completed this portion of this application and that I may be asked to verify the above information at any time.

Signature: _____

Date: _____