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

Reapplication has only one part and must be completed by the candidate.

Instructions:

A. Who Should File the Application: **Only** previously accommodated candidates seeking special testing accommodation for an Americans with Disabilities Act (ADA) disability should use this form. Use form DH-MQA 4000 if you are requesting a special testing accommodation for the first time. Use form DH-MQA 4001 if requesting an accommodation due to a religious conflict and use form DH-MQA 1192 if requesting the use of a translation dictionary.

B. Application Submission Deadline: Completed applications must 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 such 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 reschedule their examination date.

C. Required Documentation: If a complete and approved Part II of the Application for Candidates Requesting Special Testing Accommodations in Accordance with the ADA is on file and no changes have occurred in your disability, you do not need to re-file Part II of the application.

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. Emailing Information: For faster service submit your reapplication and any supplemental documentation you are sending with your application to the following email address: mqa.specialtesting@flhealth.gov.

G. Mailing information: If you cannot email your application, submit your application and any supplemental documentation you are sending with your application to the following address:

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

Note:

● Send via email or mail. Do not send your application for special testing accommodations by both email and mail.

● Do not send your request for special testing accommodations reapplication to the board office.

● Do not mail your application for licensure or examination to this address because this will delay action on your reapplication.

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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: _____

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

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) Specialty(ies) (if applicable): _____

☐ (4) Other (explain): _____

SECTION 3: FORMER SPECIAL TESTING ACCOMMODATION(S)

1. What was the date of the last examination for which Testing Services in Florida provided special testing accommodations? _____
   _____

2. Have there been any changes in your disability? ☐ Yes ☐ No

3. If Yes, please explain: _____
   _____
   _____

4. What accommodations were provided? (Check all that apply)
   - ☐ Extra time Amount of extra time provided: _____
   - ☐ Separate room
   - ☐ Other (please list): _____
     _____
     _____

SECTION 4: Certification

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: _____**