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

Prepared by

Division of Medical Quality Assurance

PART I OF THE APPLICATION FOR CANDIDATES REQUESTING SPECIAL TESTING ACCOMMODATIONS IN ACCORDANCE WITH THE AMERICANS WITH DISABILITIES ACT

APPLICATION INSTRUCTIONS:

A. Who should file: Only candidates seeking special testing accommodation for an ADA recognized disability should complete this application. Candidate seeking accommodation for religious conflict must use the application for candidates seeking accommodation due to a religious conflict.

B. Submission deadline: Completed applications should be submitted at least **sixty (60) days** prior to the examination date for which accommodations are being requested.

C. Documentation: Applications must be supported by documentation certifying the disability from a qualified professional appropriate for evaluating the disability, pursuant to Florida Statute Chapters:

- **458 (Medical Practice)**
- **459 (Osteopathic Medicine)**
- **461 (Podiatric Medicine)**
- **463 (Optometry)**
- **468 Part I (Speech-Language Pathology and Audiology)**
- **490 (Psychological Services)**
- or by a practitioner in one of these professions licensed in a comparable jurisdiction.

D. Review: Applications and supporting documentation are reviewed for completeness upon receipt by the Department. Those that are complete will be forwarded to an independent Medical Consultant for accommodation determination. Candidate applications which are incomplete or lack sufficient supporting documentation (refer to the Special Testing Accommodations for Examinees with Disabilities instructional booklet for additional details) will be notified by electronic or postal mail and have their request for accommodations placed on hold until additional support material is provided.

E. Completing the application: Please type or print all information on the application. Do not leave sections blank; place N/A in any section that does not apply.

F. Confidentiality: All material received related to special testing accommodations will be held in confidence. Always send special testing accommodation information **separately** to the address below. **Do not include these materials with an examination for licensure application.**

G. Return the application: Mail completed application and documentation to:

Florida Department of Health
Division of Medical Quality Assurance
Bureau of Operations
ATTENTION: Special Testing Coordinator
4052 Bald Cypress Way, Bin # C-90
Tallahassee, FL 32399-3260
Phone: (850) 245-4252 Fax: (850) 487-9537

Do not send request for ADA consideration with the licensure application as they are handled by separate offices and will likely cause a delay in processing.

DO NOT SEND THIS APPLICATION TO THE BOARD OFFICE.

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SECTION 1: PERSONAL DATA

a. Name: _____
First **Middle Initial** **Last**

b. Mailing Address: _____

_____
City **State/Province** **Zip Code**

c. Phone Numbers
(_____)_____ (Home) **(_____)_____(Work)**

d. Email Address: _____

SECTION 2: EXAMINATION FOR WHICH ACCOMMODATION IS REQUESTED

a. Profession: _____
b. Month/Year of Examination: _____
c. Name of the Examination (check all those that pertain and identify by name):
- o (1) **State Laws and Rules**
- o (2) **National**
  - □ (a) Practical _____
  - □ (b) Written _____
  - □ (c) Specialty/Other: _____
- o (3) **Other** (explain) _____

SECTION 3: NATURE OF THE REQUEST

o Chronic Health Problem	o Temporary Accidental Injury
o Hearing Disability	o Visual Disability
o Learning Disability	o ADHD/ADD
o Physical Disability	o Other: _____

Do you require wheelchair access at the examination site?

o Yes o No

SECTION 4: ACCOMMODATION(S) REQUESTED

Separately list each accommodation requested and the associated disability that require this accommodation.

_____ _____

_____ _____

_____ _____

If requesting paper and pencil format, specify which type of print you would like:

o Regular o Large

SECTION 5: PERSONAL STATEMENT

In order to document a 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

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

o less than 1 year o 1-2 years o 2-4 years o 5 or more years

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

(1) Secondary or elementary school o Yes o No
If yes, accommodation(s) received: _____
(If extra time, note amount given): _____

(2) College (if applicable) o Yes o No
If yes, accommodation(s) received: _____
(If extra time, note amount given): _____

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

SECTION 7: CERTIFICATION/AUTHORIZATION

I certify that the above information is true and accurate. If 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. All information regarding requests for accommodation will be treated confidentially in compliance with state and federal law. 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 OF THE APPLICATION FOR CANDIDATES REQUESTING SPECIAL TESTING ACCOMMODATIONS IN ACCORDANCE WITH THE AMERICANS WITH DISABILITIES ACT

PART II - INSTRUCTIONS FOR THE PRACTITIONER COMPLETING THIS PART

A. Who should complete Part II:

Applications for special testing accommodations must be supported by documentation certifying the disability. Documentation must be from a qualified professional appropriate for evaluating the disability, **pursuant to Chapters 458 (Medical Practice), 459 (Osteopathic Medicine), 461 (Podiatric Medicine), 463 (Optometry), 468 Part I (Speech-Language Pathology and Audiology), or 490 (Psychological Services), 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 licensed in Florida by one of the Boards listed above or as described in another state, **do not complete this form.**

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. Submission deadline: This complete Part II form should be submitted along with Part I of the application at least **sixty (60)** days prior to the examination for which special testing accommodations are requested.

C. Type or print: Do not leave any sections blank; place N/A in any section that does not apply.

D. Confidentiality: All materials received will be held in confidence.

E. Attach documentation: Document copies of the methods and tests used to diagnose the disability must be provided with Part II. Any additional observations or treatment notes should also be included.

F. Special testing accommodations requested: List accommodations that the patient will require in a testing environment and describe why the accommodation is necessary.

Return Part II to:

Department of Health
Division of Medical Quality Assurance
Bureau of Operations
ATTENTION: Special Testing Coordinator
4052 Bald Cypress Way, Bin # C-90
Tallahassee, FL 32399-3260
Phone: (850) 245–4252 Fax: (850) 487-9537

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(Please type or write legibly)

SECTION 1: PRACTITIONER DATA (The practitioner must complete this section.)

Practitioner Name: _____
Last First MI

Office Address (Include City & State): _____

_____

_____

Telephone: (_____)_____Profession: _____

Florida License No:_____ Other License No.(Inc. State): _____

Certification: _____

Specialty: _____

SECTION 2: PATIENT DATA (The Practitioner must complete this section.)

Patient Name:_____ Patient's Profession: _____

Date Patient First Consulted: _____Date Patient Last Seen: _____
Mo/day/year Mo/day/year

Diagnosis of Disability: _____

_____

Name of Test(s) or Procedures used to Diagnosis the Disability (section must be completed):_____

_____

_____

Length of Time with Condition: _____

_____

Recommended Accommodation for Testing (section must be completed): _____

_____

Reason that the Recommended Accommodations are Needed:_____

_____

SECTION 3: 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 any required accompanying documents or statements are true. I understand that pursuant to Chapter 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: _____