

Division of Professions Bureau of Education & Testing Candidate Services Examinations 2601 Blairstone Road Tallahassee, Florida 32399-0791

Phone: 850.488.5952 • Fax: 850.487.9757

Ken Lawson, Secretary Rick Scott, Governor

### APPLICATION FOR CANDIDATE'S REQUESTING SPECIAL TESTING ACCOMMODATIONS

### PART I

This application should be submitted by the final published application deadline for the published month and year of the candidate's assigned examination. Requests must be supported by documentation certifying the disability from a qualified professional appropriate for evaluating the disability, licensed 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. Review of a request for test accommodations will be deferred until the necessary documentation is submitted. Mail your completed application and documentation to:

> Department of Business and Professional Regulation Bureau of Education and Testing ATTENTION: Special Testing Coordinator 2601 Blairstone Road Tallahassee, FL 32399-0791

Phone: 850.487.9755 Fax: 850. 487.9757 www.MvFloridalicense.com/dbpr

Pleas	e type or prin		ery romanions	осони форт			
1.	<ul><li>a. Pro</li><li>b. Spe</li></ul>	lations are requested fession: cialty (if applicable): nth/Year of Exam:		ng examination	n:		
2.	Name:	st	First	Mid	dle Initial		
3.	Address: Street			Apt#			
	(	City	S	tate/Province	Zip Code		
	<u>.(</u> 1	) Phone Numbers	(Home)	_()	(Work)		
SS numl allow eft must als	ne Federal Privacy A pers are mandatory pricient screening of a so be recorded on all	pursuant to Title 42 US Code, Supplicants and licensees by a Title	ections 653 and 654; a le IV-D child support ( license applications a	and 455.203(9), 409.25 (CS) agency to assure cond will be used for lice	required by Federal statute. In this instance 577, 409.2598, F.S. SS numbers are used to ompliance with CS obligations. SS number ensee identification pursuant to the Persona Sec. 317.		
5.	Nature of Disability:						
	☐ Chronic☐ Hearing☐ Learning☐ Physical☐	g Disability		<ul><li>□ Temporary Accidental Injury</li><li>□ Visual Disability</li><li>□ Other:</li></ul>			

6.	In order to document your need for accommodation as completely as possible, please attach, in addition to professional documentation, a personal statement describing your disability and its impact on your daily life and educational functioning.							
7.	How long ago was your disability first professionally diagnosed?							
	□ less than 1 year □ 1-2 years □ 2-4 years □ 5 or more years							
8.	What $accommodation(s)$ are you requesting? Accommodation(s) must be appropriate to the disability.							
9.	Do you require wheelchair access at the examination facility?  ☐ Yes ☐ No							
10.	Prior classroom or examination accommodation(s) that you have received:							
	A.	•	elementary sch modation(s) rec		☐ Yes	□ No		
	B.	College (if no If yes, accom	eeded) modation(s) rec	ceived:	☐ Yes	□ No		
	C.		tion(s) received, note amount g		)			
11.	Certifi	cation/Authori	ization:					
include until I h taking t	a deviation	tion from the stan opleted it, I will no nination and I wi	ndard testing time ot communicate	e schedule, I agre in any way, to the	ee that, from the t e extent possible	nmodations granted to me time I begin the examination e, with any other individuals riduals about the content of		
Signat	Signature: Date:							
authori of my d Statute Depart the dis	zation to lisability. s. If clar ment of l ability a	determine eligib This information iffication or further Business and Pr nd/or those ent	oility for a reasona on will remain cor er information req rofessional Regu tities to commur	able accommoda ofidential pursuar garding the docur lation authority to dicate with the E	tion in regard to to provisions in nentation provide contact the prof Department of E	information obtained by this this examination by reason in Chapter 455.229, Floridated is needed, I authorize the ressional(s) who diagnosed Business and Professional in further information.		
Signature: Date:								

6.



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# **PART II**

# APPLICATION FOR DISABILITY ACCOMMODATION

Requests must be supported by documentation certifying the disability from a qualified professional appropriate for evaluating the disability, *licensed 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. (Please write legibly)

PRACTITIONER NAME		
PRACTITIONER NAMELAST	FIRST	MI
OFFICE ADDRESS	TELEPHONE	
		(WITH AREA CODE)
NAME OF PATIENT	PROFESSION	
DATE PATIENT FIRST CONSULTEDN	DATE PATIENT LAST SEEN	MO/DAY/YR
DIAGNOSIS OF DISABILITY		
NAME OF TEST(S) USED		
LENGTH OF TIME WITH CONDITION		
RECOMMENDED ACCOMMODATION FOR 1	TESTING	
Please note:		
I hereby certify that the above inform release information by my patient.	ation is true and is given pursuar	nt to the authorization to
Under penalties of perjury, I declare accompanying documents or statemerause for loss of a license or denial completed this portion of this applicat at any time.	ents are true. I understand that for the standing of the following in the standard for the	alse information may be certify that I personally
Signature	Date	
State License Number		
E A 2 T	DEPARTMENT OF BUSINESS AND PROBUREAU OF EDUCATION and TESTING ATTENTION: SPECIAL TESTING 2601 BLAIRSTONE ROAD FALLAHASSEE, FL 32399-0791 PHONE 850.487.9755 FAX 850.487.975	

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