

**APPLICATION FOR CANDIDATES 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 and 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:

FACE Special Accommodations

C/O Professional Testing, Inc.

Attention: Nancy Hibjan

301 E. Pine St., Suite 505

Orlando, FL 32801

Phone: (407) 264-2993

Fax: (407) 264-2855

Please type or print.

1. Accommodations are requested for the following examination:

a. Profession: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Parts Desired: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Month/Year of Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First Middle Initial

3. Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip Code

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Work)

4. Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Under the Federal Privacy Act, disclosure of Social Security (SS) numbers is voluntary unless specifically required by Federal statue. In this instance, SS numbers are mandatory pursuant to Title 42 US Code, Sections 653 and 654; and 455.203(9), 409.2577, 409.2598, F.S. SS numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support (CS) agency to assure compliance with CS obligations. SS numbers must also be recorded on all professional and occupational license applications and will be used for licensee identification pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act), 104 Pub. L. 193, Sec. 317.

5. Nature of Disability:

□ Chronic Health Problem □ Temporary Accidental Injury

□ Hearing Disability □ Visual Disability

□ Learning Disability □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Physical Disability

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 professionally diagnosed?

□ less than 1 year □ 1-2 years □ 3-4 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 test accommodation(s) that you have received:

a. Secondary or elementary school □ Yes □ No

If yes, accommodations received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. College (if needed) □ Yes □ No

If yes, accommodations received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Other

Accommodations received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11. Certification/Authorization:

I certify that the above information is true and accurate. If test accommodations granted to me include a deviation from the standard test 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 Professional Testing, Inc. 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. If clarification or further information regarding the documentation provided is needed, I authorize Professional Testing, Inc. authority to contact the professional(s) who diagnosed the disability and/or those entities to communicate with Professional Testing, Inc. in this regard to provide Professional Testing with such clarification and/or further information.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**APPLICATION FOR DISABILITY**

**ACCOMMODATION**

PART II

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 and Audiology), Florida Statutes.

Practitioner Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip Code

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Profession: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Patient First Consulted: \_\_\_\_\_\_\_\_\_\_\_\_\_ Date Patient Last Seen: \_\_\_\_\_\_\_\_\_\_\_\_\_

Mo/Day/Yr Mo/Day/Yr

Diagnosis of Disability: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Test(s) Used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Length of Time with Condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Recommended Accommodation for Testing:**

I hereby certify that the above information is true and is given pursuant to the authorization to release information by my patient.

Under penalties of perjury, I declare that the foregoing statements and those in any required accompanying documents or statements are true. I understand that 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State License Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please return this form to:***

FACE Special Accommodations

C/O Professional Testing, Inc.

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