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

Prior to completing the application, we strongly recommend that your 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
- ☐ Any additional supplemental documentation
- ☐ PART II – Application instructions to be completed by a Florida licensed health care practitioner requesting special testing accommodations
- ☐ Supporting Documentation from a qualified health care practitioner

Mailing information:

Required documentation must 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 sixty (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 will 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. 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.

- ☐ PART I – Application instructions to be completed by the candidate requesting special testing accommodations
- ☐ Personal Statement
- ☐ Any additional supplemental documentation

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 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 application for special testing accommodations 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 FOR CANDIDATES REQUESTING SPECIAL TESTING ACCOMMODATIONS IN ACCORDANCE WITH THE AMERICANS WITH DISABILITIES ACT

PERSONAL DATA

1. Name: _____
   First Middle Last

2. Mailing Address: _____
   Street Apt. Number

   _____
   City State Zip Code

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

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) Specialty (ies) (if applicable): _____

___ (4) Other (explain): _____

NATURE OF REQUEST

1. Please select the nature of your request:

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

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

☐ Yes ☐ No

ACCOMMODATION(S) REQUESTED

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

_____
_____
_____
_____

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.

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): _____

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 sixty (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 will 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 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 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 application for special testing accommodations 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 II - APPLICATION FOR CANDIDATES REQUESTING SPECIAL TESTING ACCOMMODATIONS IN ACCORDANCE WITH THE AMERICANS WITH DISABILTIES ACT

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)

PATIENT DATA

1. Patient Name: _____
   First Last MI

2. Patient Profession: _____

3. Date Patient First Consulted: _____
(Month / Date / Year)

4. Date Patient Last Seen: _____
(Month / Date / Year)

5. Diagnosis of Disability: _____

6. Name of Test(s) or Procedures Used to Diagnose the Disability:
_____
_____
_____
_____

7. Length of Time with the Condition: _____

8. Recommended Accommodation for Testing:
_____
_____

9. Reason that the Recommended Accommodations are Needed:
_____
_____
_____

SUPPORTING DOCUMENTATION

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.

CERTIFICATION / AUTHORIZATION

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: _____**