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 complete this application. If applying for the first time or for an accommodation due to a religious conflict, request an application for special testing accommodations for initial applicants or for candidates seeking accommodation due to a religious conflict.

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: 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.

☐ Reapplication for candidates requesting special testing accommodations in accordance with the Americans with Disabilities Act

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. Mailing information:
Submit your reapplication 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 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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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) Specialty (ies) (if applicable): _____

___ (4) Other (explain): _____

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): _____
   _____
   _____

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: _____**