

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
1940 North Monroe Street
Tallahassee, FL 32399-0791
Phone: 850.487.9755 Fax: 850. 487.9757
www.MyFlorida.com/dbpr

Please type or print.

1. Accommodations are requested for the following examination:
 - a. Profession:
 - b. Specialty (if applicable):
 - c. Month/Year of Exam:

2. Name:

Last	First	Middle Initial
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3. Address:

Street		
City	State/Province	Zip Code
() _____ (Home)	() _____ (Work)	
Phone Numbers		

4. **Social Security Number:**
Under the Federal Privacy Act, disclosure of Social Security (SS) numbers is voluntary unless specifically required by Federal statute. 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 & Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act), 104 Pub. L. 193, Sec. 317.

5. Nature of Disability:

<input type="checkbox"/> Chronic Health Problem <input type="checkbox"/> Hearing Disability <input type="checkbox"/> Learning Disability <input type="checkbox"/> Physical Disability	<input type="checkbox"/> Temporary Accidental Injury <input type="checkbox"/> Visual Disability <input type="checkbox"/> Other:
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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(Optomerty), or 468, Part I (Speech Language Pathology & Audiology), Florida Statutes. (Please write legibly)*

PRACTITIONER NAME _____
LAST FIRST MI

OFFICE ADDRESS _____ TELEPHONE _____
(WITH AREA CODE)

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 _____

Please note:

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:

DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION
BUREAU OF EDUCATION and TESTING
ATTENTION: SPECIAL TESTING
1940 NORTH MONROE STREET
TALLAHASSEE, FL 32399-0791
PHONE 850.487.9755 FAX 850.487.9757
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