Florida dbpr Department of Business & Professional Regulation

Division of Professions
Bureau of Education & Testing
Candidate Services Examinations
2601 Blair Stone 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:

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Department of Business and Professional Regulation
Bureau of Education and Testing
ATTENTION: Special Testing Coordinator
2601 Blair Stone Road
Tallahassee, FL 32399-0791
Phone: 850.487.9755 Fax: 850. 487.9757
www.MyFloridalicense.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

3. Address:
   Street Apt#

   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:

- ❑ Chronic Health Problem
- ❑ Hearing Disability
- ❑ Learning Disability
- ❑ Physical Disability
- ❑ Temporary Accidental Injury
- ❑ Visual Disability
- ❑ Other:

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. Secondary or elementary school ❑ Yes ❑ No
       If yes, accommodation(s) received:

    B. College (if needed) ❑ Yes ❑ No
       If yes, accommodation(s) received:

    C. Other Year
       Accommodation(s) received:
       (If extra time, note amount given: ________________)

11. Certification/Authorization:

I certify that the above information is true and accurate. If examination 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 Business and Professional Regulation 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 provisions in Chapter 455.229, Florida Statutes. If clarification or further information regarding the documentation provided is needed, I authorize the Department of Business and Professional Regulation authority to contact the professional(s) who diagnosed the disability and/or those entities to communicate with the Department of Business and Professional Regulation in this regard to provide the Department with such clarification and/or further information.

Signature: ______________________________________ Date:

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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____
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
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