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

Prepared by

Practitioner Reporting & Examination Services

Bureau of Operations

Division Of Medical Quality Assurance

Completion of this form meets the requirements under 64B-1.005, Florida Administrative Code (F.A.C.), for candidates reapplying for special testing accommodations in accordance with the Americans with Disabilities Act. (ADA)

Revised 2/2011

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REAPPLICATION INSTRUCTIONS:

A. Who Should File the Application: Previously accommodated candidates seeking special testing accommodation for an 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 or by the final published application deadline for the examination for which you are requesting accommodations.

C. Documentation Needed: If a complete and approved Part II of the Application for Candidates Requesting Special Testing Accommodations in Accordance With the Americans with Disabilities Act is on file and no changes have occurred in your disability, you do not need to re-file Part II of the application.

D. Review: Review of a request for special testing accommodations will begin after this form is received and is complete.

E. *Please* type or print all information on the application. Do not leave sections blank. Put NA if the section does not apply.

F. Returning the Application: Do not send your request with your licensure application because this will delay action on your application. Mail your completed application for requesting special testing accommodations and documentation to:

Department of Health
Bureau of Operations, Practitioner Reporting &
Examination Services
ATTENTION: Special Testing Coordinator
4052 Bald Cypress Way, Bin # C-90
Tallahassee, FL 32399-3260

Phone: (850) 245 - 4252 Fax: (850) 487-9537

Do not mail your application for licensure or examination to this address.

DO NOT SEND THIS APPLICATION TO THE BOARD OFFICE.

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SECTION 1: PERSONAL DATA

a. Name:_____
Last First Middle Initial

b. Address: _____
Street Apt. Number

_____
City State Zip Code

c. Phone Numbers: ( )_____**(Home) ( )**_____ **(Work)**

SECTION 2: EXAMINATION FOR WHICH ACCOMMODATION IS REQUESTED

a. Profession: _____

b. Month/Year of Exam: _____

c. 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)** _____

SECTION 3: FORMER SPECIAL TESTING ACCOMMODATION(S):

a. What was the date of the last examination for which Testing Services in Florida provided special testing accommodations? _____

b. Have there been any changes in your disability? ❑ Yes ❑ No
If yes, please explain:_____
_____

SECTION 4: ACCOMMODATION(S) PROVIDED:

1. What accommodations were provided? (Check all that apply)

❑Extra time (Amount of extra time: _____)

❑Separate room

❑Other (please list):

_____

_____

SECTION 7: Certification/Authorization:

I certify that the above information is true and accurate. If 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 provisions in Section 455.647, 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: