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

Prepared by

Division of Medical Quality Assurance

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

REAPPLICATION INSTRUCTIONS:

A. Who should file: 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. Submission deadline: Completed applications should be submitted at least **sixty (60) days** prior to the examination date for which accommodations are being requested.

C. Documentation: 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. Completing the application: Please type or print all information on the application. Do not leave sections blank; place N/A in any section that does not apply.

F. Confidentiality: All material received related to special testing accommodations will be held in confidence. Always send special testing accommodation information **separately** to the address below. **Do not include these materials with an examination for licensure application.**

G. Return the application: Mail completed application and documentation to:

Florida Department of Health
Division of Medical Quality Assurance
Bureau of Operations
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 send request for ADA consideration with the licensure application as they are handled by separate offices and will likely cause a delay in processing.

DO NOT SEND THIS APPLICATION TO THE BOARD OFFICE.

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SECTION 1: PERSONAL DATA

a. Name: _____
First **Middle Initial** **Last**

b. Mailing Address: _____

_____
City **State/Province** **Zip Code**

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

d. Email Address: _____

SECTION 2: EXAMINATION FOR WHICH ACCOMMODATION IS REQUESTED

a. Profession: _____
b. Month/Year of Examination: _____
c. Name of the Examination (check all those that pertain and identify by name):
- o (1) **State Laws and Rules**
- o (2) **National**
  - □ (a) Practical _____
  - □ (b) Written _____
  - □ (c) Specialty/Other: _____
- o (3) **Other** (explain) _____

SECTION 3: FORMER SPECIAL TESTING ACCOMMODATION(S):

a. What was the date of the last examination for which Florida provided special testing accommodations? _____
b. Have there been any changes in your disability? o Yes o No
If yes, please explain: _____
_____

SECTION 4: ACCOMMODATION(S) PROVIDED:

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

- o Extra time (Amount of extra time: _____)
- o Separate room
- o Other (please list):

_____

_____

If requesting paper and pencil format, specify which type of print you would like:

o Regular o Large

SECTION 5: 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. All information regarding requests for accommodation will be treated confidentially in compliance with state and federal law. 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: _____