FLORIDA DEPARTMENT OF HEALTH

Division of Medical Quality Assurance

Application for Candidates Requesting Testing Accommodations in Accordance with the Americans with Disabilities Act

Psychology Laws and Rules Examination

Computer-Based Test (CBT)

Effective September 15, 2015

PART 1: To be completed by applicant

APPLICATION INSTRUCTIONS

A. Who should file: Only candidates seeking testing accommodation for a disability under the Americans with Disabilities Act should complete this application.

B. Timeline: The application will be processed promptly. Submitting the application early will allow for processing time and improve your chances of finding a convenient appointment time, as exam appointments are made on a first-come first-served basis.

C. Documentation: Applications must be supported by documentation certifying the disability. The documentation must come from a professional qualified to evaluate the disability, pursuant to Florida Statute Chapters:

- 458 (Medical Practice)
- 459 (Osteopathic Medicine)
- 461 (Podiatric Medicine)
- 463 (Optometry)
- 468 Part I (Speech-Language Pathology and Audiology)
- 490 (Psychological Services)

or by a practitioner in one of these professions licensed in a comparable jurisdiction.

D. Review: Applications and supporting documentation are reviewed upon receipt. Candidates whose applications are incomplete will be notified by electronic or postal mail and have their request for accommodations placed on hold until additional support material is provided.

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 testing accommodations will be held in confidence. Always send testing accommodation information **separately** to the address below. **Do not include these materials with an examination for licensure application.**

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

ATTN: FLDOH ADA
Professional Testing, Inc.
7680 Universal Blvd Ste 300
Orlando FL 32819

Fax: 1-407-264-2855

DO NOT SEND THIS APPLICATION TO THE BOARD OFFICE.

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SECTION 1: PERSONAL DATA

a. Name _____
First Middle Last

b. Mailing Address _____

City _____ State/Province _____ Zip Code _____

c. Phone Numbers

(_____) _____ (Home) (_____) _____ (Work)

d. Email Address _____

SECTION 2: ACCOMMODATION REQUESTED

❑ Additional 30 minutes (total exam time = 90 minutes)

❑ Additional 60 minutes (total exam time = 120 minutes)

❑ Separate room

❑ Reader and separate room

❑ Reader and separate room and additional _____ minutes

❑ Adjustable/Larger Font

SECTION 3: PERSONAL STATEMENT

Please attach a personal statement describing your disability and its impact on your daily life and educational functioning.

SECTION 4: LENGTH OF TIME AND PRIOR ACCOMMODATIONS

1. How long ago was your disability first professionally diagnosed?

❑ less than 1 year ago ❑ 1–2 years ago ❑ 3–4 years ago ❑ 5 or more years ago

2. Specify any prior classroom or test accommodations that you have received.

❑ Elementary or secondary school

Accommodation received (including amount of extra time, if applicable): _____

_____

❑ College and medical school

Accommodation received (including amount of extra time, if applicable): _____

_____

❑ Other

Accommodation received (including amount of extra time, if applicable): _____

_____

SECTION 4: CERTIFICATION AND AUTHORIZATION

I certify that the information above and in the attached statement is true and accurate.

I understand the Department of Health, through its designee Professional Testing, Inc., will use the information obtained by this application 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.

I authorize the Department of Health, through its designee, to contact the professional(s) who diagnosed the disability for any clarification needed, and I authorize said professionals to provide such clarification.

Signature: _____ Date: _____

PART 2: To be completed by practitioner certifying disability

INSTRUCTIONS

A. Who should complete Part 2: Applications for testing accommodations must be supported by documentation certifying the disability. Documentation must be from a professional qualified to evaluate the disability, **pursuant to Chapters 458 (Medical Practice), 459 (Osteopathic Medicine), 461 (Podiatric Medicine), 463 (Optometry), 468 Part I (Speech-Language Pathology and Audiology), or 490 (Psychological Services), *Florida Statutes.*** A practitioner in the same field practicing in another state may certify the disability if the practitioner is licensed in that state and was practicing the profession at the time the diagnosis was made. If you are not licensed in Florida by one of the boards listed above or by another state, as described above, **do not complete this form.**

If you are not a psychologist, medical physician, osteopathic physician, podiatrist, or optometrist, or licensed to practice speech and language pathology and audiology, **do not complete this form.**

Professionals conducting assessments and rendering diagnoses of learning disabilities must be qualified to do so. Comprehensive training in the differential diagnosis of various learning disabilities is required. The evaluator should provide professional credentials, including information about licensure or certification, the area of specialization and employment. Please designate the state where practicing.

B. 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.

C. Confidentiality: All material received will be held in confidence.

D. Documentation: The methods and tests used to diagnose the disability must be documented. Any additional observations or treatment notes should also be included.

E. Accommodations: Please list accommodations that the patient will require in a testing environment and describe why the accommodation is necessary.

F. Return the application: Send completed application and documentation to:

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SECTION 1: PRACTITIONER DATA

a. Name _____
First Middle Last

b. Office Address _____

City _____ State/Province _____ Zip Code _____

c. Telephone (_____) _____ d. Profession _____

e. License Number _____ State _____

f. Certification_____

g. Specialty _____

SECTION 2: PATIENT DATA (completed by practitioner)

a. Patient Name _____ b. Patient's Profession _____

c. Date Patient First Consulted _____ d. Date Patient Last Seen _____

e. Diagnosis of Disability _____

_____

f. Name of Test(s) or Procedures used to Diagnosis the Disability (section must be completed) ____

_____

_____

g. Length of Time with Condition _____

_____

h. Recommended Accommodation for Testing (section must be completed):_____

_____

i. Reason that the Recommended Accommodations are Needed: _____

_____

SECTION 3: CERTIFICATION

I hereby certify that the above information is true and is given pursuant to the authorization to release information by my patient. I declare that the foregoing statements and those in any required accompanying documents or statements are true. I understand that pursuant to Chapter 456.067, *Florida Statutes,* the act of giving 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:_____