

**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  
2601 Blairstone Road  
Tallahassee, FL 32399-0791  
Phone: 850.487.9755 Fax: 850.487.9757  
[www.MyFloridaLicense.com/dbpr](http://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
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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:

<input type="checkbox"/> Chronic Health Problem	<input type="checkbox"/> Temporary Accidental Injury
<input type="checkbox"/> Hearing Disability	<input type="checkbox"/> Visual Disability
<input type="checkbox"/> Learning Disability	<input type="checkbox"/> Other:
<input type="checkbox"/> Physical Disability	



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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(Optomtry), 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  
2601 BLAIRSTONE ROAD  
TALLAHASSEE, FL 32399-0791  
PHONE 850.487.9755 FAX 850.487.9757  
[www.MyFloridalicense.com/dbpr](http://www.MyFloridalicense.com/dbpr)