APPLICATION FOR INDIVIDUALS REQUESTING SPECIAL EXAMINATION ACCOMMODATIONS

STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

APPLICATION FOR INDIVIDUALS REQUESTING SPECIAL EXAMINATION ACCOMMODATIONS

This application should be submitted by the *application deadline for the month and year of the applicant's examination.*

Requests must be supported by documentation certifying the disability from a qualified professional appropriate for evaluating the disability, licensed pursuant to Chapters 460 (Chiropractic), 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 examination accommodations will be deferred until the necessary documentation is submitted. Mail your completed application and documentation to:

Department of Juvenile Justice
Bureau of Staff Development and Training
Certification Unit
ATTN: Staff Development and Training Administrator
2737 Centerview Drive
Tallahassee, Florida 32399-3100

(Please type or print)

1. Accommodations are requested for the following examination: (Please check one)

   ☐ JCO ☐ JDO ☐ JPO ☐ PAR

   Month and Year of Exam: _____

2. Name: _____
   Last First Middle Initial

3. Address: _____
   Street

   _____ _____ _____
   City State Zip Code

   _____ (Home) _____ (Work)
   Telephone Number Telephone Number

4. Last Five Digits of Social Security Number: _____

5. Nature of Disability:
   - ☐ Chronic Health Problem
   - ☐ Hearing Disability
   - ☐ Learning Disability
   - ☐ Other: _____
   - ☐ Temporary Accidental Injury
   - ☐ Visual Disability
   - ☐ Physical Disability

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 test accommodation(s) that you have received:
    A. Secondary or elementary school ☐ Yes ☐ No
       If yes, accommodation(s) received: _____

    B. College (if appropriate) ☐ Yes ☐ No
       If yes, accommodation(s) received: _____

    C. Academy Year _____
       If yes, accommodation(s) received: _____
       If extra time given, note amount given: _____

11. Certification and Authorization:

    I certify that the above information is true and accurate. If examination accommodations granted to me include a deviation from the standard examination 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 Juvenile Justice 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. If clarification or further information regarding the documentation provided is needed, I authorize the Department of Juvenile Justice authority to contact the professional(s) who diagnosed the disability and/or those entities to communicate with the Department of Juvenile Justice in this regard to provide the Department with such clarification and/or further information.

Signature: _____ Date: _____

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Please write legibly

PRACTITIONER NAME _____ _____ _____
LAST FIRST MI

OFFICE ADDRESS _____ _____ _____
STREET CITY/STATE ZIP 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 ACCOMODATION FOR EXAMINATION _____

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, pursuant to Section 837.06, F.S., 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 certification or denial of possible certification. 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:
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Certification Unit
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