Physical Therapist/Physical Therapist Assistant Applicant
Special Accommodations Request Form

Section I – Applicant Information

Name: ____
Last First Middle

Current Street Address: ____________________________________

City: __________________ State: ________ Zip Code: __________________

Home Phone Number: ______________ Alternate Phone Number: ______________

Email Address: ____

Date of Birth ______ /____ /______ Gender (circle one): Male or Female
Month Day Year

Section II – Information About Your Disability and Requested Accommodations

Describe the nature of your disability. ***Please indicate the specific diagnosis.***

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When was your disability last diagnosed? ______________________

What major life activity is limited by your disability and how?

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How does your disability affect your ability to take the examination?

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What accommodations are you requesting during the examination?

_____ Additional Time – 30 Minutes

_____ Additional Time – Time and a Half

_____ Additional Time – Double Time

_____ Zoom Text

_____ Screen Magnifier

_____ Separate Room

_____ Reader

_____ Scribe

_____ Colored Overlays

_____ Ear Plugs

_______ Other ____

Section III – Documentation Requirements

A comprehensive and current report (received within the previous year from the exam date), from a professional specified under 645–200.4(5), must accompany this "request for accommodation" form. The report must include:

- Name, title, credentials and area of specialization of the professional making the diagnosis and accommodation recommendation;
- Specifications of the limited major life activities that leads to the necessity of the accommodation(s);
- A diagnosis of the disability pursuant to any applicable or recognized professional standard;
- Verification of the professionally recognized diagnostic tests used on the applicant and the applicant's test results;
- Recommendation and rationale for the accommodation;
- SIGNATURE by the professional confirming the accuracy of the report.

Section IV – Candidate Affirmation

My signature on this form affirms that the information I have provided on this request is true and accurate. I have truthfully represented my disability and the impact it has on my daily life and computerized examinations.

______________________________________ ______________________

Applicant Signature Date