FLORIDA CERTIFICATION BOARD

Special Accommodations Policy

It is the policy of the FCB to offer reasonable and appropriate accommodations to candidates who have a documented visual, physical, hearing, or learning disability covered by the Americans with Disabilities Act (ADA) which would prevent them from taking an examination under standard conditions.

In considering a request for special accommodations, FCB will be guided by industry best practice, which seeks to provide qualified candidates with the opportunity to be examined in an equivalent manner as other candidates but not to provide an advantage over other candidates. The FCB will review each request on an individual basis. There is no additional cost to examinees who are approved for accommodations.

Requests for special accommodations must be submitted to the FCB a minimum of 30 calendar days before the requested exam date. Documentation supporting the request for special accommodations must meet the following criteria:

1. Documentation must be from a medical professional qualified and licensed to assess and diagnose the specific presenting disability.
2. Documentation must be recent (within no more than 2 years from the date of the request).
3. Documentation must be submitted on the medical professional's letterhead and must include:
    a. A current, valid, professionally recognized diagnosis of the candidate's disability pursuant to the Diagnostic and Statistical Manual of Mental Disorders.
    b. A clear description of the nature and extent of the functional limitations that exist as a result of the diagnosed disability.
    c. Specific information about the significance of the impact the disability has on the candidate in the testing environment.
    d. Specific recommendations for accommodations with an explanation of why each accommodation is recommended/why it is necessary to alleviate the impact of the disability in taking the examination.

All documentation will be kept in confidence and will be disclosed to FCB staff only to the extent necessary to evaluation the accommodation.

The FCB reserves the right to request additional information from the individual requesting accommodations.

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Please complete this form to request special testing accommodations. Supporting documentation from a qualified medical provider must be attached to this form. The information provided will be held in strict confidence. **This form and all supporting documentation is due to the FCB at least 30 calendar days before testing.**

Part 1: Candidate Information. Provide requested information EXCTLY as is associated with your FCB account**.**

Name: ______________________________

Email Address: ______________________________

Telephone Number: ______________________________

I am requesting special accommodations. I understand that my request must be supported by recent information and documentation from a medical professional pursuant to FCB's Special Accommodations Policy. I further understand that any cost related to collecting documentation is my personal responsibility; however, I will not bear any cost for approved accommodations provided to me at an FCB test site.

______________________________ ______________________________

Candidate Signature *(FCB accepts both manual and electronic signatures)* **Date**

Part 2: Documentation of Eligibility for Special Accommodations. Please have this section completed by a qualified and licensed medical provider and request supporting documentation, which you will attach to this form.

I have evaluated ______________________________ on ______________ in my capacity
(examination candidate) *(date)*

as a ______________________________
(Professional Title)

The examination candidate listed above discussed with me the nature of the examination to be administered. I understand the exam is a 100 to 125 item, multiple-choice exam administered on a computer in a proctored testing site. Candidates have two hours to complete the exam. It is my opinion that, because of the candidate's disability, he or she should receive the testing accommodations described below. I have provided the candidate with the supporting documentation requested by FCB policy to support my recommendation.

Check all that apply:

- ❑ Extended testing time (specify total hours requested):___________________________
- ❑ Distraction free room/tested separately
- ❑ Reader
- ❑ Scribe
- ❑ Other (please specify)____

Medical Professional Name: ______________________________

Email Address: ______________________________

Telephone Number: ______________________________

______________________________ ______________________________

Medical Professional Signature *(FCB accepts both manual and electronic signatures)* **Date**