State of Florida
Department of Business and Professional Regulation
Bureau of Education & Testing
Application for Special Testing Accommodations
Form # DBPR 2002-064

APPLICATION CHECKLIST – IMPORTANT – Submit all items on the checklist below with your application to ensure faster processing.

APPLICATION	APPLICATION REQUIREMENTS
Part I. **Request for Special Testing Accommodations**	❑ Complete Sections I, II, III and IV. 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.
Part II. **Practitioner Statement**	❑ Complete Section V. This section of the application must be completed by the practitioner.

Please email, fax or mail your completed application & documentation to:

Department of Business and Professional Regulation
Bureau of Education and Testing
ATTENTION: Special Testing Coordinator
2601 Blair Stone Road
Tallahassee, FL 32399-0791
Email: BETSpecialTesting@myfloridalicense.com
Fax: 850.487.9757

Instructions

*If you have any questions or need assistance in completing this application, please contact the, Bureau of Education & Testing, at: **BETSpecialTesting@myfloridalicense.com** or at 850.487.9755.*

1. **General Requirements**
   - **a.** Documentation for a learning disability must be completed by an appropriate professional and include:
     - i. The diagnosis and length of time with the condition;
     - ii. The name and the results of the test(s) used for diagnosis; and,
     - iii. Recommended accommodations and testing environment.

2. **Application instructions (by section):**
   - **a. Section I – Profession Type**
     - i. Please select only one profession type.
   - **b. Section II – Applicant Information**
     - i. Provide name and Social Security number. A Social Security number is required in order to apply for any individual license within the Department of Business and Professional Regulation.
     - ii. Provide your mailing address, telephone number and e-mail address. This will be used for sending correspondence to you.
   - **c. Section III – Professional Documentation**
     - i. Please select the nature of your disability
     - ii. Be sure to include a personal statement describing your disability and its impact on your daily life and educational functioning.
     - iii. Be sure to attach professional documentation certifying the disability from a qualified professional.
     - iv. Please select the type of accommodation you are requesting and whether or not wheelchair access to the examination facility is required.
   - **d. Section IV – Affirmation By Written Declaration**
     - i. Applicant must sign the affirmation by written declaration.
   - **e. Section V – Practitioner Statement**
     - i. Provide practitioner name.
     - ii. Provide office address.
     - iii. Complete patient information. Be sure to fill out section completely.
     - iiv. Practitioner must sign the affirmation by written declaration.

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For additional information see the Instructions at the beginning of this application.
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Section I – Profession

CHECK ONE OF THE PROFESSION TYPES BELOW		
❑ Accountancy	❑ Certified Drug Representative	❑ Geologist
❑ Architecture	❑ Community Association Managers	❑ Harbor Pilots
❑ Auctioneers	❑ Construction	❑ Landscape Architecture
❑ Barbers	❑ Cosmetology	❑ Real Estate Appraiser
❑ Building Code	❑ Electrical Contractors	❑ Real Estate Sales / Brokers
		❑ Veterinary Medicine

Section II – Applicant Information

APPLICANT INFORMATION			
Last/Surname	First	Middle	Suffix
Social Security Number			
MAILING ADDRESS			
Street Address or P.O. Box			
City		State	Zip Code (+4 optional)
County (if Florida address)		Country	
Primary Phone Number	Primary E-Mail Address		

*Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by Federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code, Sections 653 and 654; and Sections 455.203(9), 409.2577, and 409.2598, Florida Statutes. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to assure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for licensee identification pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act), 104 Pub.L.193, Sec. 317.

Section III – Nature of Disability

DISABILITY

❑ Chronic Health Problem
❑ Hearing Disability
❑ Learning Disability
❑ Physical Disability
❑ Temporary Accidental Injury
❑ Visual Disability
❑ Other:

PERSONAL STATEMENT

PROFESSIONAL DOCUMENTATION

Requests must be supported by documentation certifying the disability from a qualified professional appropriate for evaluating the disability.

Do you have professional documentation certifying the disability from a qualified professional?

❑ Yes (If yes, please attach documentation to this application)
❑ No

How long ago your disability was first professionally diagnosed?

❑ Less than 1 year ❑ 1-2 years ❑ 2-4 years ❑ 5 or more years

ACCOMODATION REQUESTS

Do you require wheelchair access at the examination facility?

❑ Yes
❑ No

What accommodation(s) are you requesting? (Accommodation must be appropriate to the disability.)

❑ Extra Time – (Time and a Half) ❑ Separate Room ❑ Separate Room & Recorder

❑ Extra Time – (Double Time) ❑ Separate Room & Reader ❑ Separate Room & Reader/Recorder

❑ Other (Please Explain) ____

Section IV – Affirmation By Written Declaration

AFFIRMATION BY WRITTEN DECLARATION	
I certify that I am empowered to execute this application as required by Section 559.79, Florida Statutes. I understand that my signature on this written declaration has the same legal effect as an oath or affirmation. Under penalties of perjury, I declare that I have read the foregoing application and the facts stated in it are true. **I understand that falsification of any material information on this application may result in criminal penalty or administrative action, including a fine, suspension or revocation of the license.**	
Signature:	Date:
Print Name:	

Section V – Practitioner Statement (To be completed by practitioner)

PRACTICIONER INFORMATION			
Practitioner Name	First	Middle	Suffix
State License Number			

MAILING ADDRESS		
Office Address		
City	State	Zip Code (+4 optional)
County (if Florida address)	Country	
Primary Phone Number		

PATIENT INFORMATION	
Patient Name	
First Consultation Date	Most Recent Consultation Date
Diagnosis of Disability	
Name of Test(s) Used	

Length of Time with condition

❑ Less than 1 year ❑ 1-2 years ❑ 2-4 years ❑ 5 or more years

Recommended Accommodation for Testing

❑ Extra Time – (Time and a Half) ❑ Separate Room ❑ Separate Room & Recorder

❑ Extra Time – (Double Time) ❑ Separate Room & Reader ❑ Separate Room & Reader/Recorder

❑ Other (Please Explain)____

AFFIRMATION BY WRITTEN DECLARATION

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:
Print Name:	