



THE STATE
of

ALASKA

Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

Professional Licensing

PO Box 110806, Juneau, AK 99811

Phone: (907) 465-2550

Email: License@Alaska.Gov

Website: ProfessionalLicense.Alaska.Gov

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Examination Accommodations for Candidates with Disabilities Application

The Americans with Disabilities Act (ADA) ensures that individuals with disabilities have the opportunity to compete fairly for and pursue employment opportunities by requiring testing entities to offer exams in an accessible manner.

Check with your specific program first as they may have other accommodation options.

All documentation must be received by the application deadline for the exam for which you are applying. Our office will work with you to make this process as smooth as possible and will notify you if you have been granted accommodation within two weeks of receipt of a completed form. The testing entity may require additional information.

PART I Personal Information

Full Legal Name:			
Mailing Address:	P.O. Box or Street	City	State Zip
Contact Phone:		Date of Birth:	
Email Address:			
Professional License Applied for:		Record Number (If Known):	

PART II Personal History

List your physical or mental impairment(s) that substantially limits one or more major life activities:	<input type="checkbox"/> N/A
How does the impairment affect your ability to take the examination for the license you are applying for?	<input type="checkbox"/> N/A

PART III Accommodations

Based on your current disability and functioning, and in consultation with the diagnosing professional (if relevant) or prior examination accommodation, I am requesting the following accommodations (check all that apply):

Large type test booklet (if available)

Architecturally accessible test site and accommodation:

Reader (with separate room and proctor)

Sign language interpreter:

For opening instructions only

For the entire test

Separate room and proctor (not due to use of reader, writer, or sign interpreter)

Extended time:

25% Extra

50% Extra

75% Extra

100% Extra

Writer (to record answers on answer sheet)

Other accommodation(s):

Have you previously received this accommodation(s) while taking a similar examination(s)?

No

Yes

If no, I understand I must have the Qualified Professional Recommendation Form (#08-4449a) completed and submitted.

If yes, I understand I must submit documentation verifying the prior examination date, type, and accommodation.

Signature

I certify the above information is true and correct to the best of my knowledge. I also authorize the State of Alaska to release the information provided to parties involved in providing the accommodation requested.

Candidate Signature:

Date Signed:



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**Examination Accommodations for Candidates with Disabilities –
Qualified Professional Recommendation Form**

This form must be completed by a licensed, certified, or otherwise qualified professional whose credentials are appropriate to diagnose, evaluate, and treat the disability. The professional must have diagnosed, evaluated, or treated the candidate within the last three years and have current knowledge of the candidate’s disability and its impact on major life activities.

→ **Candidate:** Complete the identifying information below and forward a copy of this form to the professional who diagnosed, evaluated or treated you in the last three years.

Candidate Name:		Date of Birth:	
Professional License and/or Examination Requested:			

→ **Qualified Professional:** Complete this bottom part for the candidate identified above and return the form directly to the candidate or to the letterhead address.

PART I Personal Information

Professional Name:		Title:	
Mailing Address:	P.O. Box or Street	City	State Zip
Email Address:		Contact Phone:	
Profession:		License Number:	
State of Licensure:		Currently Licensed?	<input type="checkbox"/> Yes <input type="checkbox"/> No

PART II Diagnosis and Treatment

Diagnosis:
If there is a specific learning disability or mental/psychiatric disorder, provide the DSM-V diagnosis and code. A copy of the psychological, psychiatric, or educational assessment report with test scores must be enclosed.

Describe the manner in which this disability impairs major life activity:

PART II Diagnosis and Treatment *(continued)*

Provide the last date of your treatment or consultation with the candidate:

PART III Accommodations

Based on my knowledge of this candidate's disability and current functioning, and in consultation with the candidate, the following accommodations are recommended (check all that apply):

Large type test booklet (if available)

Architecturally accessible test site and accommodation:

Reader (with separate room and proctor)

Sign language interpreter:

For opening instructions only

For the entire test

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75% Extra

100% Extra

Writer (to record answers on answer sheet)

Other accommodation(s):

Signature

I certify the above information is true and correct to the best of my knowledge. I also authorize the State of Alaska to release the information provided to parties involved in providing the accommodation requested.

Professional's Signature:

Date Signed: