FDLE
Florida Department of Law Enforcement

APPLICATION FOR INDIVIDUALS REQUESTING SPECIAL TEST ACCOMMODATIONS

Incorporated by Reference in Rule 11B-30.0071(2), F.A.C.

CJSTC 502

Please type or print in black or blue ink

PART I

Pursuant to Rule 11B-30.0071(2), F.A.C., this form shall be submitted 45 calendar days prior to the requested test date. Requests shall 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 or certified as a School Psychologist by the Florida Department of Education), 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. Mail your completed application and documentation to:

Florida Department of Law Enforcement Criminal Justice Professionalism Services
Bureau of Training Certification Examination Section
ATTENTION: ADA Coordinator
P.O. Box 1489Tallahassee, Florida 32302-1489

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

   ☐ Law Enforcement ☐ Correctional ☐ Correctional Probation

   Requested Administration Date and Location: _____

2. Name: _____
   Last First MI

3. Address: _____

   _____
   City State or Province Zip Code

Home Phone Number: (____) _____ Work Phone Number: (____) _____

4. Enter Four Digit Social Security Number: XXX-XX-_____

5. Nature of Disability:

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

6. To document your need for accommodation as completely as possible, please attach, in addition to professional documentation, a personal statement describing in detail your disability and its impact on your ability to care for yourself; participate in routine daily tasks such as grocery shopping and interacting with others and function in an educational environment.

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. Please note, pursuant to Rule 11B-30.007, F.A.C., a reader cannot be provided for the State Officer Certification Examination.

_____

_____

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 needed) ☐ Yes ☐ No

If yes, accommodation(s) received: _____

C. Academy Year:_____

If yes, accommodation(s) received: _____

If extra time was given, please note the amount of time given: _____

11. Certification and Authorization

I certify that the above information is true and accurate. If the test accommodations granted to me include a deviation from the standard testing time scheduled, 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 Florida Department of Law Enforcement 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 Florida Department of Law Enforcement authority to contact the professional(s) who diagnosed the disability and those entities to communicate with the Florida Department of Law Enforcement in this regard to provide the Department with such clarification and further information.

Signature:_____ Date: _____

PART II

Please print legibly, or type in blue or black ink

Requests shall 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 or certified as a School Psychologist by the Florida Department of Education), 458 (Medical Practice), 459 (Osteopathy), 461(Podiatry), 463(Optometry), or 468, Part I (Speech Language Pathology & Audiology), Florida Statutes.

Practitioner's Name: _____
Last First MI

Office Address: _____

Office Telephone Number: _____

Name of Patient: _____

Profession: _____

Date patient was first consulted: _____ Date patient was last seen: _____
Month Day Year Month Day Year

Diagnosis of Disability: _____

Name of Test(s) Used: _____

Length of Time with Condition: _____

Recommended Accommodation for Testing: _____

_____

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 mine and that they 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 examined and evaluated the patient whose name appears on this form and, as a result of that evaluation, that I have 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: _____

Submit this form to the following address: Florida Department of Law Enforcement, Criminal Justice Professionalism Program, Bureau of Training/Examination Section, P.O. Box 1489, Tallahassee, Florida 32302-1489.