

SOUTH DAKOTA DEPARTMENT OF LABOR AND REGULATION
SOUTH DAKOTA BOARD OF BARBER EXAMINERS
221 W. Capitol Ave., Suite 101, Pierre SD 57501
Tel: 605.773.6193 barber@state.sd.us

INSTRUCTIONS APPLICATION FOR DISABILITY ACCOMMODATION

The Application for Disability Accommodations, Form ADA, is to help the state barber board determine (1) whether you are a qualified disabled individual under applicable state or federal law, and (2) whether the accommodation you are requesting is reasonable. Consideration of all requests will be made under applicable laws, including the Americans with Disabilities Act.

Part I: The information requested on Part I of the form is self-explanatory. You are not required to furnish your social security number, but this information would be most helpful in identifying you and relating Form ADA to other parts of your examination application. After you have completed Part I, Form ADA should be dated and signed by you and notarized by a Notary Public in your jurisdiction.

Part II: Part II of Form ADA should be completed by your health care practitioner or other appropriate professional and signed and dated where indicated.

Submission of the Form: This form must be submitted before the state board can make a decision on any examination accommodations requested.

Please consult with the board to determine the appropriated application process and relevant deadlines.

A submitted Form ADA will remain valid for one year from the date when executed by the applicant. A valid Form ADA should be considered for any examination occurring within this one-year period provided the candidate makes a request for consideration prior to the examination date. Forms not fully completed will be returned to the applicant.

Questions may be directed to the board at 605.773.6193. Please submit Parts I and II of Form ADA at the same time. Under any circumstances, it is recommended that you retain a copy of this form for your records.

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LICENSURE EXAMINATION
APPLICATION FOR DISABILITY ACCOMMODATION

PART I

Name _____ SSN # _____
Last First M.I.
Address _____ Birth Date _____
Telephone Number _____
Disability _____

Physicians or Other Health Care Practitioners:

(a) Name _____
Office Address _____
Length of Time as Patient _____
Street City State Zip Code

(b) Name _____
Office Address _____
Length of Time as Patient _____
Street City State Zip Code

Accommodations(s) Requested _____

USE ADDITIONAL SHEETS, IF NECESSARY

Release

I authorize each health care practitioner listed above to release to the South Dakota Board of Barber Examiners, or their designated representatives, information which will verify the current functional limitations imposed by my disability which affect my ability to perform under standard testing conditions; and describe the nature of the examination accommodation(s) being proposed and the rationale for those accommodation(s). I further understand that I may be asked to provide additional information about my functional limitation(s) and the requested accommodations and agree to cooperate with reasonable requests for such additional information.

I understand and agree that the information obtained by this authorization will be used solely for the purpose of determining my eligibility for reasonable accommodations in regard to the barber licensure process and the nature and extent of the accommodations which are reasonably necessary by reason of my disability. The information obtained by this authorization will not be released or disclosed to any person or organization except the referenced parties, and any other governmental agency that may be involved in acting upon my request for reasonable accommodations in connection with the barber licensure process.

I agree that this authorization shall be valid until canceled or revoked in writing by me.

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 denial or loss of a license. I hereby certify that I personally completed this application and that I may be asked to verify the above information at any time.

Signature _____ Date _____

Subscribed to and sworn to before me this _____ day of _____, 20_____.

Notary Public _____

PART II

Practitioner Name _____
Last First M.I.

Office Address _____
Street City State Zip Code

Telephone Number _____

Patient's Name _____

Patient's Address _____

Patient's SSN# - -

Date Patient First Consulted _____

Date Patient Last Seen _____

Diagnose and Describe Condition:

I hereby certify that the above information is true and is released pursuant to the authorization by my patient.

Signature of Health Practitioner _____

Professional Status _____
(Physician, Psychologist, etc.)

License Number (If Applicable) _____

Date _____
Month Day Year

FOR BOARD USE

Board approval, if applicable _____
Name Title Date