Complete and use the button at the end to print for mailing.

SD EForm - 1448 V1

HELP

# FORM A

## REASONABLE TESTING ACCOMMODATIONS QUESTIONNAIRE

(To be completed by all applicants who request reasonable testing accommodations)

NOTE: This form is part of the Application for Admission to Practice Chiropractic in South Dakota. Applicants are responsible for completeness and accuracy of the information provided. If you are requesting a reasonable testing accommodation, the following forms must be completed and returned with your application.

Background Information:
Applicant Name: _____

Social Security Number: _____

| | | | |
|---|---|---|---|
| | | SD | |
| Address | City | State | Zip |

Telephone Number: _____ Exam Date: _____

Nature of disability (Check all that apply):

- ☐ Blind
- ☐ Visually impaired
- ☐ Hearing impaired
- ☐ Other physical disability
- ☐ Psychological disability
- ☐ Specific learning disability
- ☐ Chronic health problem
- ☐ Temporary accidental injury
- ☐ Other _____

My condition is:

Describe the nature and extent of your disability.

How long have you had your disability?
○ 1 year ○ 3 years ○ 5 years or more ○ Most of my life

Past Accommodations Granted:

| | YES | NO |
|---|---|---|
| Were you in a specific school or program to accommodate your disability? | ○ | ○ |
| Did you receive accommodations for classroom tests? | ○ | ○ |
| Did you receive additional testing time for classroom tests? | ○ | ○ |

Were you granted testing accommodations for taking prior South Dakota or other jurisdiction licensure exams? Y ◯ N ◯ List state, date, and accommodation received

_____

Please describe the accommodations you were given during chiropractic school or other examinations.

Please describe any additional accommodations you were granted while in college and/or law school.

Requested Accommodations:
Please check below the accommodation(s) that you believe are necessary for you to take the South Dakota Chiropractic licensure examination.

- ☐ Braille version of test
- ☐ Large print test book
- ☐ Audio cassette version of test
- ☐ A scribe
- ☐ Additional testing time for each test session. (Please specify amount of additional time requested)_____
- ☐ Other
- ☐ Use of a tape recorder
- ☐ Use of a reader
- ☐ Rest periods
- ☐ Sign-language/interpreter

Applicant's Signature

I understand that all the information on this form is true and correct and that it may be reviewed by a physician and licensed professional.

_____ _____
Signature Date

If you are unable to sign this form, please have someone sign and date it in your presence.

_____ _____
Signature of individual signing on behalf of applicant Date

1. PRINT FOR MAILING CLEAR FORM