FORM B

REASONABLE TESTING ACCOMMODATIONS DISABILITY DOCUMENTATION

(To be completed by a physician or licensed professional for all applicants)

NOTE: The South Dakota Chiropractic Board of Examiners requires current documentation (within the last three years) from a licensed physician or other professional in the field related to the applicant's disability. Applicant must return this form with his/her completed Application to Practice Chiropractic in South Dakota.

(Please type)

Physician or Licensed Professional:

Name: _____

Title: _____

License/Certification Number: _____

Address: _____

Telephone Number: _____

RE: Applicant Name: _____

Please describe your credential(s) which qualify you to diagnose and/or verify the applicant's disability and to recommend an accommodation:

_____

_____

What is the specific diagnosis, condition, or physical impairment that requires testing accommodations?

_____

_____

Briefly describe the nature of the condition and describe how this condition affects the applicant.

_____

_____

Current treatment consisted of : _____

_____

_____

Last date of treatment/date of consultation with applicant:

_____

Length of treatment with applicant: _____

Is this a permanent condition/disability? ____Yes ___No

If no, when is the condition/disability likely to abate? _____

_____

In what way does the condition/disability affect the applicant's ability to read, write and/or concentrate for extended periods of time? _____

_____

_____

Based on this person's disability and your diagnosis, what testing accommodations would you recommend? (Check all that would apply.)

___ Regular print test book
___ Braille version of test
___Audio cassette version of test
___ Large print 18 pt.) test book
___ Rest periods during test session
___ Additional testing time -- Please specify: _____- per session. If a specific amount of additional testing time is NOT indicated, the petition cannot be processed.
___ A reader
___ A scribe to record responses or to aid in the writing sample portion of the test
___ Test room and restrooms accessible by wheelchair
___ Medications. If so, identify: _____
___ Sign-language/interpreter
___ A magnifying glass
___ Other _____

Please explain how the recommended accommodation relates to the disability _____

_____

_____

Please complete Supplemental Form B-LD for learning disability requests. I certify that all the information on this form is true and correct to the best of my knowledge and belief.

_____

Signature of Physician/Licensed Professional Name (print) Date

NOTE: I understand this information may be reviewed by a physician or licensed professional retained by the Board of Chiropractic Examiners to assist in determining reasonable testing accommodations.