Instructions
Application for Disability Accommodations
Form ADA (2001)
South Dakota Board of Hearing Aid Dispensers and Audiologists

The Application for Disability Accommodations, Form ADA, is to help the state hearing aid dispensers and audiologists 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 605-642-1600. 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.

SOUTH DAKOTA BOARD OF HEARING AID DISPENSERS AND AUDIOLOGISTS

135 East Illinois, Suite 214
Spearfish, SD 57783

FORM ADA (2001)

LICENSURE EXAMINATION
APPLICATION FOR DISABILITY ACCOMMODATION

PART I

Name _____ SSN # ☐☐☐-☐☐-☐☐☐☐
Last First M.I. Optional - See Instructions

Address_____ Birth Date ☐☐-☐☐-☐☐

_____

Telephone Number ☐☐☐-☐☐☐-☐☐☐☐

Disability_____

_____

Physicians or Other Health Care Practitioners:

(a) Name_____

Office Address_____
Street City State Zip Code

Length of Time as Patient_____

(b) Name_____

Office Address_____
Street City State Zip Code

Length of Time as Patient_____

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 Hearing Aid Dispensers and Audiologists, 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 hearing aid dispenser 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 hearing aid dispenser 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 here by 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_____

THIS APPLICATION IS VALID FOR A PERIOD OF ONE (1) YEAR FROM THE DATE WHEN FIRST EXECUTED BY THE APPLICANT. (SEE INSTRUCTIONS)

SOUTH DAKOTA BOARD OF HEARING AID DISPENSERS AND AUDIOLOGISTS
135 East Illinois, Suite 214
Spearfish, SD 57783

FORM ADA (2001)

APPLICATION FOR DISABILITY ACCOMMODATION PRACTITIONER'S STATEMENT

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