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.

(Please type)
Background Information:
Applicant Name: _____

Social Security Number: _____

Address: _____

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? 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
___ Use of a tape recorder
___ Use of a reader
___ Rest periods
___ Sign-language/interpreter
___ Additional testing time for each test session. (Please specify amount of additional time requested)_____
___ Other

_____

_____

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