

SOUTH DAKOTA BOARD OF BARBER EXAMINERS

810 N. Main St., Suite 298, Spearfish, SD 57783 Tel: 605.642.1600

FORM B

REASONABLE TESTING ACCOMMODATIONS DISABILITY DOCUMENTATION

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

Physician or Licensed Professional

Name: _____

Title: _____

License/Certification Number: _____

Address: _____

Telephone Number: _____

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 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? _____

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Based on this person's disability and your diagnosis, what testing accommodations would you recommend?

- | | |
|--|---|
| <input type="checkbox"/> Regular print test book | <input type="checkbox"/> Rest periods during time session |
| <input type="checkbox"/> Additional Testing time | <input type="checkbox"/> -per session. |
| <input type="checkbox"/> A reader | <input type="checkbox"/> Test room and restrooms accessible by wheelchair |
| <input type="checkbox"/> Sign-language/Interpreter | <input type="checkbox"/> Other _____ |

Please explain how the recommended accommodation relates to the disability

I certify that all the information on this form is true and correct to the best of my knowledge.

Signature of Physician/Licensed Professional

Name (print)

Date