SOUTH DAKOTA DEPARTMENT OF LABOR AND REGULATION
SOUTH DAKOTA COSMETOLOGY COMMISSION
217 W. Missouri Ave., Pierre, SD 57501
Tel: 605.773.6193 Fax: 605.773.7175 cosmetology.sd.gov

FORM B
REASONABLE TESTING ACCOMMODATIONS DISABILITY DOCUMENTATION

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

NOTE: The Cosmetology Commission requires current documentation (within the last three years) from a licensed physician or other professional in the field related to the applicant's disability.

Fill, print, sign, and mail or email to the address above.

Physician or Licensed Professional:

Name: ______________________________

Title: ______________________________

License / Certification Number : ______________________________

Address, City, State Zip: ______________________________

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 or consultation with the 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 an extended period(s) 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
- 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
- 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:

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

Name: ____

Date: ____

Signature of Physician/Licensed Professional: ____

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