SOUTH DAKOTA DEPARTMENT OF LABOR AND REGULATION
SOUTH DAKOTA BOARD OF BARBER EXAMINERS
217 West Missouri Avenue, Pierre SD 57501
Tel: 605.773.6193 barber@state.sd.us

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: _____

Tel: (_____) _____- _____ License/Certification Number: _____

Address: _____

PATIENT/APPLICANT

Applicant Name: _____

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

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

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/orconcentrate for extended periods of time?

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

☐ Regular print test book
☐ Additional Testing time
☐ A reader
☐ Sign-language/Interpreter
☐ Test room and restrooms accessible by wheelchair
☐ Other:_____

☐ Rest periods during time session
☐ -per session.

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 **Date**