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STATE OF DELAWARE
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DIVISION OF PROFESSIONAL REGULATION

Delaware Examining Board of Physical Therapists and Athletic Trainers

APPLICANT SPECIAL ACCOMMODATIONS REQUEST FORM

Section I – Applicant Information

Name: _____
Last First Middle

Current Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Alternate Phone Number: _____

Email Address: _____

Date of Birth: ____/____/____
Month Day Year

Gender (check one): Male Female

Section II – Information About Your Disability and Requested Accommodations

What type of disability do you have? *Please indicate the specific diagnosis.*

When was your disability first diagnosed? _____

How does your disability affect your daily life?

How does your disability affect your ability to take computerized examinations?

What accommodations are you requesting during the examination?

- | | |
|--|--|
| <input type="checkbox"/> Additional Time – Time and a half | <input type="checkbox"/> Reader |
| <input type="checkbox"/> Additional Time – Double Time | <input type="checkbox"/> Scribe |
| <input type="checkbox"/> Paper and Pencil Exam | <input type="checkbox"/> Separate Room |
| <input type="checkbox"/> LARGE PRINT Paper and Pencil Exam | <input type="checkbox"/> Other _____ |

What accommodations have you received in the past for the following exams?

National Physical Therapy Exam _____

PT/PTA School Exams _____

Undergraduate College Exams _____

Standardized Exams (e.g., SAT, GRE, etc.) _____

Section III – Documentation Requirements

A comprehensive and current report (no more than three years old) from a qualified examiner appropriate for evaluating your disability must accompany this request form. The report must include the following:

- Name, title, credentials and area of specialization for the qualified examiner
- Specific diagnosis
- Specific findings in support of the diagnosis (include relevant test results)
- Recommendation for specific accommodations
- Rationale for requesting specific accommodations

Section IV – Candidate Affirmation

My signature on this form affirms that the information I have provided on this request is true and accurate. I have truthfully represented my disability and the impact it has on my daily life and computerized examinations.

Applicant Signature

Date