Arkansas Department of Health
State Board of Physical Therapy
P.O. Box 250254 • Little Rock, AR 72225
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Special Accommodations Request Form

Name: _____
Last **First** **Middle**

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

_____

_____

_____

When was your disability first diagnosed? _____

What accommodations are you requesting during the examination?

_____ Additional Time - Time and a half

_____ Additional Time – Double Time

_____ Zoom Text

_____ Screen Magnifier

_____ Reader

_____ Scribe

_____ Separate Room

_____ Other

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

_____ _____
Applicant Signature Date