



Arizona Department of Agriculture

1688 W. Adams Street, Phoenix, Arizona 85007
(602) 542-3578 FAX (602) 542-0466

Americans with Disabilities Act Accommodations Request Packet

Contents:

- Americans with Disabilities Act Accommodations Request Information
- Applicant Accommodation Request Form
- Professional Evaluation Form

Contact our Americans with Disabilities Act (ADA) Representative:

Melissa Meek – Human Resources Manager

Human Resources

mmeek@azda.gov

602-542-0925; or

if unavailable, you may contact:

Robert L Tolton, Jr. – Licensing Administrator

Licensing

rtolton@azda.gov

602-255-3652



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AMERICANS WITH DISABILITIES ACT (ADA) ACCOMMODATIONS REQUEST

The Arizona Department of Agriculture (AZDA) strives to provide an equal testing opportunity for all applicants. The purpose of any special accommodation is to ensure that the examination results reflect an applicant's aptitude or other factor that the exam is designed to measure, rather than reflecting the applicant's sensory, manual or psychological skills (except where those skills are factors the exam is designed to measure).

All applicants requesting an accommodation should take the time to carefully complete this packet before submitting their request. A completed Accommodation Request Packet includes the Applicant Accommodations Request Form, the Professional Evaluation Form and any additional verification required. A complete packet will allow the AZDA to assist the applicant in arranging the best accommodation possible for the situation. We are unable to process incomplete Accommodation Requests.

Completed Accommodation Request Packet will be reviewed within 48 hours and will be kept confidential. Accommodations will be arranged as quickly as possible and at either no extra charge to the candidate, or possibly at the actual cost of providing the accommodation.

We are here to help you. Please contact the Accommodations Representative listed on the front cover of this Exam Accommodation Request Packet, to answer any questions or concerns about who signs where, or what type of accommodation would work best for you, or to simply walk through the request process.

To help you in your request, please keep the following in mind as you complete this packet:

1. All test sites are wheelchair accessible – no request is required.
2. You **MUST** either have an appropriate qualified professional (an internist, for example, is not an qualified professional to diagnose a mental disorder or reading disability) complete the Professional Evaluation Form **OR** provide existing documentation from the person(s) who granted you the same or similar accommodation you are now requesting in another formal testing environment (the Professional Evaluation Form must still be returned with the appropriate box marked). Qualified Professionals are licensed or otherwise properly credentialed and possess expertise in the disabilities for which modifications or accommodations are sought.
3. We **CANNOT** make any accommodations of a "personal nature" (lifting or feeding, for example).
4. If you choose to provide existing documentation of a similar accommodation, you may be required to provide additional verification.



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APPLICANT ACCOMMODATION REQUEST FORM

Applicant Name: _____ PMD ID Number (10-digits) #: _____

Address: _____ City: _____ State: _____ Zip: _____

Daytime Phone Number: _____ Other Number: _____ Fax Number: _____

E-mail: _____

Certification Exam(s) Requested

Agricultural:

Non-Agricultural:

Weights & Measures:

Exam Site Requested:

Earliest Date you are Available to Test:

Diagnosed Disability:

Accommodation Requested (Please note: if an accommodation is made, it may be limited.)

Extended Time (please specify how long) _____ (Note - unlimited time is not reasonable and will not be considered)

Distraction-Free Room

Permission to bring and take medications during the exam (i.e. blood sugar monitor and insulin)

Other (please specify) _____

PLEASE READ AND SIGN:

I authorize release of attached forms to AZDA staff to review and, if approved, arrange the requested accommodation.

I give my permission for my diagnosing professional to discuss with AZDA staff my records and history in as much as they relate to the requested or suggested accommodation.

I understand and agree that AZDA staff may provide my records to an appropriate professional selected by AZDA for an independent evaluation relating to my request or to the State or local agency for which the exam is administered.

I understand that if I choose to provide existing documentation of the same or similar accommodation, I may be required to provide additional verification, including completion of the Professional Evaluation Form.

Signature: _____ Date: _____



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QUALIFIED PROFESSIONAL EVALUATION FORM

To the Professional:

By submitting this form with your signature and license number listed, you are verifying you have formally diagnosed the applicant named on this form as having the disability documented below or, in your professional capacity, you have worked with the applicant in dealing with the disability documented on the following page. You further verify the accommodation you recommend is necessary to fairly demonstrate the applicant's ability in a licensure exam.

The purpose of any special accommodation is to ensure that the examination results reflect an applicant's aptitude or other factor the exam is designed to measure, rather than reflecting the applicant's sensory, manual or psychological skills (except where those skills are factors the exam is designed to measure). Our intent is to provide equal opportunity for all applicants. The accommodation must not unfairly advantage or disadvantage the applicant.

Please call us if you have any questions regarding the exam or response format, physical environment, required documentation or determination of appropriate and reasonable accommodations. For example, while extended time is a reasonable accommodation, providing a written paper exam for a computer-based test or a computer-based test for a written paper exam is an extremely difficult request to honor and is generally not considered reasonable. Finally, the AZDA is unable to accommodate a request for a "reader" or "unlimited time". If extra time is needed, please specify the amount.

Exam Applicant Name: _____



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PROFESSIONAL EVALUATION (To be completed by a Qualified Professional)

Professional's Printed Name:

Address:

Email:

Phone No.:

Fax No.:

License No.:

Current Status:

Issuing State:

Board Certification:

Professional's Signature:

Date:

I have known the applicant, _____, since _____
(Name of applicant) (date)

in my capacity as a:

(Please provide existing documentation from person(s) who granted similar accommodations in another formal testing environment, if applicable.)

The applicant has been diagnosed with the following disability (Note: mental and emotional disabilities must include diagnosis code from DSM-III-R or DSM-IV, or successor text.):

(Attach additional pages if needed)

The applicant or AZDA staff has discussed with me the nature of the test to be administered. It is my opinion that because of the applicant's disability, the applicant, should be accommodated by AZDA providing the following:

(Attach additional pages if needed)