



SANITARIAN REGISTRATION PROGRAM

Mail Code 1982, P.O. Box 149347

Austin, Texas 78714-9347

www.dshs.state.tx.us/sanitarian

(512) 834-4517



Budget: ZZ103

Fund: 151

Name: _____

Request for Disability Accommodation for Sanitarian Examination

If you have a disability requiring appropriate accommodations in taking the state examination, be sure to complete this form along with the application. **In addition, attach a statement on letterhead stationery from a professional who is familiar with your disability.** This statement must describe the disability for which you require accommodation.

1. Do you have any disability-related needs that we should be made aware of in order to provide appropriate accommodations for the examination? YES NO If the answer is YES, please specify.

Disability: _____

2. Have you had any prior accommodations for your disability in an examination setting? YES NO If you answer YES, specify the type of accommodation. Have a professional familiar with your disability complete this information, if needed.

Disability	Type of Test Accommodation
_____	_____
_____	_____
_____	_____

3. If you have NOT had prior accommodation for a test, what do you feel would aid you in taking the examination? If you cannot answer this question by yourself, have a professional who knows your disability and the type of accommodation you need help answer this question. This professional could be a physician, psychologist, rehabilitation counselor, or other professional.

Disability	Type of Test Accommodation
_____	_____
_____	_____
_____	_____

Please sign and date the bottom of this form. Make sure the professional who helps you complete the form also signs and dates this form. **Be sure to submit a statement on letterhead stationery from a professional who is familiar with your disability.**

Signature (Applicant) _____ Date _____

Signature (Professional) _____ Date _____