



Arkansas Department of Health

Arkansas State Board of Physical Therapy

5800 W. 10th, Suite 100 • Little Rock, AR 72204

(501) 228-7100 • Fax: (501) 228-0294

arptb@arkansas.gov • www.arptb.org

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 | _____ Reader |
| _____ Additional Time – Double Time | _____ Scribe |
| _____ Zoom Text | _____ Separate Room |
| _____ Screen Magnifier | _____ 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