THE SCHOOL DISTRICT OF PHILADELPHIA
BOARD OF EDUCATION
440 NORTH BROAD STREET
PHILADELPHIA, PENNSYLVANIA 19130

OFFICE OF TALENT

TELEPHONE (215) 400-4610
FAX (215) 400-4613

Justification for Testing Accommodation

INSTRUCTIONS TO APPLICANTS: If you have a disability that requires an accommodation **in testing**, this form must be completed by an appropriate professional (i.e. education professional, physician, vocational rehabilitation counselor, psychologist, or psychiatrist) to certify that your disabling condition requires testing accommodation(s). Please be sure to complete both pages of this form and return it to hrexams@philasd.org.

If you have previously submitted documentation to request the same or a similar accommodation for a School District of Philadelphia examination, you may submit a copy of that material instead of completing a new form.

CERTIFICATION

(Please print or type the requested information)

Applicant's Name: ____.

Social Security No.: 000-00-____________ Examination: ____________________.
(Last four digits only)

I certify that this applicant is a current patient/client of mine. I also certify that because of this applicant's disability, he/she should be accommodated by providing the following (check all that apply; you may provide additional information as needed on the back of this page):

- ☐ Audio recorded test
- ☐ Extended time
- ☐ Separate testing area
- ☐ Large print test (Font Size __________)
- ☐ Use of adaptive equipment provided by candidate (specify): ______________.
- ☐ Other accommodation (specify): ______________________________.

Please return this completed form **(2 pages)** to **hrexams@philasd.org**.

NOTE: If this form is not returned within 24 hours of receiving the exam invitation, the Office of Talent may not be able to approve the accommodation request in time for the current testing round.

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Certifying professional's name (print): ______________________________________.

Date of last appointment w/ above-named individual: ____________________________.

Title: ______________________________________.

License # (if applicable): ____________________Telephone #: ____________________.

Email address: ____.

Signature: ________________________________ Date:____________________.

NOTE: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Please return this completed form **(2 pages)** to hrexams@philasd.org.

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