



# Arizona Department of Agriculture

## Office of Pest Management

1688 W. Adams Street, Phoenix, Arizona 85007

(602) 542-3578 FAX (602) 542-0466

<https://agriculture.az.gov>

## **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:

Danielle Salomon – Human Resources Manager

Arizona Department of Agriculture

Human Resources

1688 W. Adams St.

Phoenix, AZ 85007



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### **AMERICANS WITH DISABILITIES ACT (ADA) ACCOMMODATIONS REQUEST**

The Arizona Department of Agriculture - Office of Pest Management (OPM) 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).

We ask all applicants requesting an accommodation to 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 OPM to assist the applicant in arranging the best accommodation possible for the situation. We are unable to process incomplete Accommodation Requests.

Completed Accommodation Request Packets 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 professional (an internist, for example, is not an appropriate 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).
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: \_\_\_\_\_

ID Number (10-digit # assigned by the OPM): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Daytime Phone Number: \_\_\_\_\_ Other Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

Name and License Category of Exam(s) Requested:

\_\_\_\_\_

\_\_\_\_\_

Exam Site Requested: \_\_\_\_\_

Earliest Date you are Available to Test: \_\_\_\_\_

Disability: \_\_\_\_\_

Accommodation Requested (Please note: if an accommodation is made, it may be limited. For example, a reader for someone taking an exam may only read the question & possible answers, not additional data such as labels, graphs, photos, etc. A reader may not provide any explanation, descriptions or comments.)

\_\_\_\_\_ Reader \_\_\_\_\_ Scribe

\_\_\_\_\_ Extended Time (please specify; unlimited time is not available) \_\_\_\_\_

\_\_\_\_\_ Other (please specify) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

#### PLEASE READ AND SIGN:

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

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

I understand and agree that OPM staff may provide my records to an appropriate professional selected by OPM 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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### PROFESSIONAL EVALUATION FORM

To the Professional:

By submitting this form with your signature and license number listed, you are verifying that 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 that 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 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). 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 a reader or scribe 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 a VERY difficult request to honor and is generally not considered reasonable. Finally, the OPM is unable to accommodate a request for "unlimited time". If extra time is needed, please specify the amount.

Exam Applicant Name: \_\_\_\_\_



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www.azda.gov

### PROFESSIONAL EVALUATION (To be completed by a Licensed Professional)

Exam Applicant Name: \_\_\_\_\_

Diagnosis: (Note: mental and emotional disabilities must include diagnosis code from DSM-III-R or DSM-IV, or successor text.)

I have known \_\_\_\_\_ (applicant) since \_\_\_\_\_ (date) in my capacity as a \_\_\_\_\_.

The applicant has been diagnosed with the following disability:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The applicant or OPM 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 OPM providing the following:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Professional: \_\_\_\_\_ Dated: \_\_\_\_\_

Name (printed): \_\_\_\_\_ Title: \_\_\_\_\_

Professional (Please Print your Name):

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Address:

---

City, State, & ZIP

Phone Number:

---

Fax Number:

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Email:

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License Number:

---

State of Licensure:

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Board Certification:

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Signature of Professional:

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Date:

(Attach additional pages if needed)

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