Instructions
Application for Disability Accommodations
Form ADA (2001)
South Dakota Board of Examiners of Psychologists

The Application for Disability Accommodations, Form ADA, is to help the state psychologist board determine (1) whether you are a qualified disabled individual under applicable state or federal law, and (2) whether the accommodation you are requesting is reasonable. Consideration of all requests will be made under applicable laws, including the Americans with Disabilities Act.

Part I: The information requested on Part I of the form is self-explanatory. You are not required to furnish your social security number, but this information would be most helpful in identifying you and relating Form ADA to other parts of your examination application. After you have completed Part I, Form ADA should be dated and signed by you and notarized by a Notary Public in your jurisdiction.

Part II: Part II of Form ADA should be completed by your health care practitioner or other appropriate professional and signed and dated where indicated

Submission of the Form: This form must be submitted before the state board can make a decision on any examination accommodations requested.

Please consult with the board to determine the appropriated application process and relevant deadlines.

A submitted Form ADA will remain valid for one year from the date when executed by the applicant. A valid Form ADA should be considered for any examination occurring within this one-year period provided the candidate makes a request for consideration prior to the examination date. Forms not fully completed will be returned to the applicant.

Questions may be directed to the board at 605-642-1600. Please submit Parts I and II of Form ADA at the same time. Under any circumstances, it is recommended that you retain a copy of this form for your records.

SOUTH DAKOTA BOARD OF EXAMINERS OF PSYCHOLOGISTS
135 East Illinois, Suite 214
Spearfish, SD 57783

FORM ADA (2001)

LICENSURE EXAMINATION APPLICATION FOR DISABILITY ACCOMMODATION

PART I

Name ______________________________ SSN # ☐☐☐-☐☐-☐☐☐☐
Last First M.I. Optional - See Instructions

Address______________________________ Birth Date ☐☐-☐☐-☐☐

____

Telephone Number ☐☐☐-☐☐☐-☐☐☐☐

Disability______________________________

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Physicians or Other Health Care Practitioners:

(a) Name______________________________

Office Address______________________________
Street City State Zip Code

Length of Time as Patient______________

(b) Name______________________________

Office Address______________________________
Street City State Zip Code

Length of Time as Patient______________

Accommodations(s) Requested______________________________

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USE ADDITIONAL SHEETS, IF NECESSARY

Release

I authorize each health care practitioner listed above to release to the South Dakota Board of Examiners of Psychologists, or their designated representatives, information which will verify the current functional limitations imposed by my disability which affect my ability to perform under standard testing conditions; and describe the nature of the examination accommodation(s) being proposed and the rationale for those accommodation(s). I further understand that I may be asked to provide additional information about my functional limitation(s) and the requested accommodations and agree to cooperate with reasonable requests for such additional information.

I understand and agree that the information obtained by this authorization will be used solely for the purpose of determining my eligibility for reasonable accommodations in regard to the psychologist licensure process and the nature and extent of the accommodations which are reasonably necessary by reason of my disability. The information obtained by this authorization will not be released or disclosed to any person or organization except the referenced parties, and any other governmental agency that may be involved in acting upon my request for reasonable accommodations in connection with the psychologist licensure process.

I agree that this authorization shall be valid until canceled or revoked in writing by me.

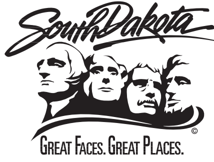
Under penalties of perjury, I declare that the foregoing statements and those in any required accompanying documents or statements are true. I understand that false information may be cause for denial or loss of a license. I here by certify that I personally completed this application and that I may be asked to verify the above information at any time.

Signature______________________________ Date______________

Subscribed to and sworn to before me this______day of______________, 20______.

Notary Public______________________________

THIS APPLICATION IS VALID FOR A PERIOD OF ONE (1) YEAR FROM THE DATE WHEN FIRST EXECUTED BY THE APPLICANT. (SEE INSTRUCTIONS)



SOUTH DAKOTA BOARD OF EXAMINERS OF PSYCHOLOGISTS
135 East Illinois, Suite 214
Spearfish, SD 57783

FORM ADA (2001)

APPLICATION FOR DISABILITY ACCOMMODATION PRACTITIONER'S STATEMENT

PART II

Practitioner Name____
Last First M.I.

Office Address____
Street City State Zip Code

Telephone Number________________________

Patient's Name____

Patient's Address____

Patient's SSN# ☐☐☐–☐☐–☐☐☐☐

Date Patient First Consulted________________________

Date Patient Last Seen________________________

Diagnose and Describe Condition:

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I hereby certify that the above information is true and is released pursuant to the authorization by my patient.

Signature of Health Practitioner________________________

Professional Status________________________
(Physician, Psychologist, etc.)

License Number (If Applicable)________________________

Date________________________
Month Day Year

FOR BOARD USE

Board approval, if applicable________________________ ____________
Name Title Date