

What reasonable accommodation(s) do you need in the testing process? (Be specific.)

BACKGROUND INFORMATION

Have you submitted a prior request for special testing accommodation to the City of San Diego Personnel Department?

Yes No If yes, was your request approved? Yes No

Please provide the name of the doctor, agency official, or other person who can verify the existence of your disability and need for special testing accommodation.

Name _____ Title _____

Agency _____ Phone Number (____) - ____ - ____

Address _____

FOR OFFICE USE ONLY: CONTACTED Yes No VERIFIED? Yes No DATE

Do you currently use the services of the California Department of Rehabilitation? Yes (Specify below) No

Name of Counselor _____ Title _____

Agency _____ Phone Number (____) - ____ - ____

Address _____

FOR OFFICE USE ONLY: CONTACTED Yes No VERIFIED? Yes No DATE

Do you currently use the services of any other agency for your disability? Yes (Specify below) No

Representative's Name _____ Title _____

Agency _____ Phone Number (____) - ____ - ____

Address _____

FOR OFFICE USE ONLY: CONTACTED Yes No VERIFIED? Yes No DATE

Is there an agency/person able to help provide the accommodation(s) you need? Yes (Specify below) No

Name _____ Title _____

Agency _____ Phone Number (____) - ____ - ____

Address _____

FOR OFFICE USE ONLY: CONTACTED Yes No VERIFIED? Yes No DATE

By my signature below, I authorize the City of San Diego to verify my request, which may include contacting all persons or agencies listed on this form. I understand that only information needed to verify the existence of my disability and need for special testing accommodation and determine potential reasonable accommodations will be requested. I need not disclose the nature of my disability.

Applicant Signature _____ Date _____

Parent/Guardian Signature & Date _____ (required ONLY if applicant is a minor)