

THE CITY OF SAN DIEGO 1200 Third Avenue, Suite 300 • San Diego, CA 92101 Telephone (619) 236-6400 • Fax (619) 236-6672

REQUEST FOR SPECIAL TESTING ACCOMMODATION

The City of San Diego is committed to ensuring that qualified applicants with a need for reasonable accommodation are treated fairly and appropriately when taking Civil Service examinations. Accommodations will be considered only to the extent necessary to give persons with permanent or temporary disabilities an equal opportunity to demonstrate their knowledge and mastery of skills in the examination. Decisions regarding accommodations shall be made by the Personnel Department on a case-by-case basis. All documentation provided to the Personnel Department is considered confidential and will be filed separately from the employment application. If you have any questions regarding your request for special testing accommodation, you may call the Testing Division Supervisor at (619) 236-6638, Monday through Friday from 9:00 a.m. to 5:00 p.m.

<u>APPLICANT</u>: Please provide the information requested below and on the second page of this form. Documentation supporting your need for special testing accommodation must be submitted with this form to:

City of San Diego Personnel Department Testing Division Supervisor 1200 Third Avenue, Suite 300 San Diego, CA 92101

Exar	n#	Exa	m Title _								
Nam	ne						P	ERNR _			
Add	ress		((ity)			(State)			(Zip Code))
Dhor))		(State)	()	(Zip Code))
FIIOI	ne Number(s) ((work			_	(other) r)		
I am	requesting special test	sting accommod	ation in th	ne area(s)) checked	below:					
	VISION	Ľ		ARING				SPEEC	H		
	HEALTH (include	s medical limitati	ons or limi	ted physic	cal tolera	nce).					
	MOTOR / ORTHOPEDIC (includes limited ambulation or mobility).										
	LEARNING (inclumented mathematical abilities	des significant di les).	fficulties in	n listening	g, reading	, reasoning,	memory,	comprehe	nsion, or	rganization,	or
	MANIPULATIVE	/ WRITING		MENTA	L / EMC	TIONAL					
	OTHER (Specify)										
Please	e describe your function	nal limitations rel	ated to the	area(s) cł	necked ab	ove:					

What reasonable accommodation(s) do you need in the testin	ng process? (Be specific.)		
BACKGROUN	DINFORMATION		
Have you submitted a prior request for special testing accom	modation to the City of Sar	n Diego Personnel Departme	ent?
□ Yes □ No If yes, was your request app	roved? \Box Ye	es 🗌 No	
<u>Please provide the name of the doctor, agency official, or and need for special testing accommodation.</u>	other person who can ver	rifv the existence of your d	<u>isability</u>
NameTit	le		
Agency	Phone Number ()	
Address			
FOR OFFICE USE ONLY: CONTACTED \Box Yes \Box No	VERIFIED? 🗌 Yes	\Box No DATE	
<u>Do you currently use the services of the California Depar</u>	tment of Rehabilitation?	\Box Yes (Specify below)	🗌 No
Name of CounselorTit	le		
Agency	Phone Number ()	
Address			
FOR OFFICE USE ONLY: CONTACTED \Box Yes \Box No		\Box No DATE	
Do vou currently use the services of any other agency for	vour disability?	(Specify below) \Box No	
Representative's Name	Title		
Agency	Phone Number ()	
Address			
FOR OFFICE USE ONLY: CONTACTED \Box Yes \Box No	VERIFIED? 🗌 Yes	\Box No DATE	
Is there an agency/person able to help provide the accom	modation(s) you need?	\Box Yes (Specify below)	🗌 No
NameTit	le		
Agency	Phone Number ()	
Address			
FOR OFFICE USE ONLY: CONTACTED \Box Yes \Box No	VERIFIED? 🗌 Yes	\Box No DATE	
By my signature below, I authorize the City of San Diego to <u>agencies listed on this form</u> . I understand that only informatic special testing accommodation and determine potential reasonature of my disability.	on needed to verify the exis	stence of my disability and r	need for
Applicant Signature	Date		
Parent/Guardian Signature & Date	(real	uired ONLY if applicant is a m	inor)