

# Wisconsin Department of Safety and Professional Services

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Madison, WI 53705  
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## OFFICE OF EDUCATION AND EXAMINATIONS

### DISABILITY MODIFICATION REQUEST FORM FOR EXAMINATIONS

This request form should be submitted by the final published application deadline date. Requests must be supported by documentation certifying the disability from a qualified professional appropriate for evaluating the disability. Review of a request for test modification will be deferred until the necessary documentation is submitted. This form and any supporting documentation may be scanned and sent via email to [DSPSExaminationsOffice@wisconsin.gov](mailto:DSPSExaminationsOffice@wisconsin.gov).

The information obtained on this form will be treated as a medical record except that exam proctors and exam providers may be informed regarding necessary modifications to exam procedures, and first aid and safety personnel may be informed, when appropriate, if the disability might require emergency treatment.

Date of Request:	<input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Candidate Full Name:	<input type="text"/>
Date of Birth:	<input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Street Address:	<input type="text"/>
City, State, Zip Code :	<input type="text"/>
Email Address:	<input type="text"/>
Telephone Number:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Credential Applied for:	<input type="text"/>
Exam Type (multiple choice, essay, oral, practical):	<input type="text"/>
Exam Name:	<input type="text"/>
Exam Date:	<input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Exam Time(s):	<input type="text"/>
Exam Location:	<input type="text"/>

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**Please respond to the following questions. Attach additional sheets if needed.**

1. What is the nature of your disability?

- |   |  |
|---|--|
| <input type="checkbox"/> Chronic Health Problem | <input type="checkbox"/> Physical Disability         |
| <input type="checkbox"/> Hearing disability     | <input type="checkbox"/> Temporary Accidental Injury |
| <input type="checkbox"/> Learning Disability    | <input type="checkbox"/> Visual Disability           |
| <input type="checkbox"/> Other _____            |  |

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2. How does your disability impair your ability to accurately exhibit your knowledge and skill level on the credentialing examination?

3. What modification are you requesting (please be specific)?

**NOTE:** Exam modifications must be appropriate to the disability. If the requested modification involves modifying the examination administration, such as additional time to complete the exam or a reader or writer, please obtain the professional verification on the following pages. If the request is limited to wheelchair space, or sitting in the front of the exam room, professional verification is not required.

## **HISTORY:**

4. When was your disability first diagnosed by a professional?

5. What modifications have you received when taking previous examinations, such as school achievement tests, or licensing examinations in other states? In addition to your answer below, please include a letter (written on school letterhead) from your most recent school or other test provider showing the testing accommodations you received while enrolled as a student and the reasons the testing accommodations were granted.