State of Illinois
Illinois Department of Public Health

Emergency Medical Services (EMS) Systems Reasonable Accommodation Request

Instruction for Completing the Reasonable Accommodation Request for Examinees With Disabilities

Standards for reasonable accommodations are set forth by the Illinois Department of Public Health. All reasonable accommodation requests must include the following:

1. A written request to modify examination procedures (time, reader, scribe, etc.) along with all other documentation. The written request should specify the modifications requested and the rationale for same.

2. A letter from the education program indicating the need for the modification and explaining how the educational program handled the situation (i.e.: separate testing area, length of additional time given.) If you were not given modifications in your educational setting, please indicate as such and explain why not in your written request above (#1).

3. A letter and detailed report from an appropriate professional person confirming the diagnosis of the disability and naming the specific disability. Include information on all tests given and their results as applicable to the diagnosis.

4. The completed "Reasonable Accommodation Request for Examinees with Disabilities" form.

5. The completed exam application or registration form and test fee, as listed on the reference sheet, MUST be received by the final filing deadline.

All reasonable accommodation requests and above documentation **MUST** be sent to:

Continental Testing Services Inc. (CTS)
P.O. Box 100
LaGrange, Illinois 60525

Your request for reasonable accommodation will not be processed for approval until all above items are received by CTS.

Please feel free to contact the CTS Special Projects Coordinator, at 800-359-1313, Ext. 104, with any questions or concerns.

State of Illinois
Illinois Department of Public Health

Emergency Medical Services (EMS) Systems Reasonable Accommodation Request

Name:

SS#:

Profession:

I. DISABILITY STATUS (check all that apply)

A. Are you ? ❑ Deaf ❑ Blind ❑ Hard of hearing ❑ Visually impaired

B. Do you have a:

❑ Physical disability?

Please explain. _____

❑ Specific learning disability?

Please explain. _____

❑ Psychological disability?

Please explain. _____

C. How long have you had your disability?

❑ Most of my life ❑ 1 year ❑ 2 years ❑ 3 years ❑ 4 years ❑ 5 years or more

II. PAST ACCOMMODATIONS MADE FOR YOUR DISABILITY

A. In high school:

Were you in a special school or program?	❑ Yes	❑ No
Did you get special accommodations for classroom tests?	❑ Yes	❑ No
Did you generally get extra time for classroom tests?	❑ Yes	❑ No

B. Did you have special accommodations for taking the SAT or ACT examinations for admission to college? ❑ Yes ❑ No

C. In college:

Did you use disabled student services?	❑ Yes	❑ No
Did you generally get extra time for exams?	❑ Yes	❑ No

D. Did you have special accommodations for examinations? ❑ Yes ❑ No
If yes, what accommodations? (Check all that apply)

Time:	Help:
❑ Extra breaks/rest periods	❑ Reader
❑ Extra testing time	❑ Recorder (scribe)
❑ Other (Please explain) _____	❑ Sign language interpreter

III. CERTIFYING STATEMENT I certify the above statements to be true.

_____ _____
Applicant Signature Date

Emergency Medical Services (EMS) Systems Reasonable Accommodation Request

Name:

SS#:

Profession:

IV. ACCOMMODATIONS REQUEST FOR EXAMINATION (check all that apply)

Time: ❑ Extra breaks/rest periods ❑ Extra testing time

Help: ❑ Reader ❑ Recorder ❑ Sign language interpreter

Other (Please explain): _____

_____

V. SABBATH OBSERVER:

To ask that your test be administered on a day other than Saturday or a holy day, please submit a letter on letterhead stationery, signed by your rabbi or minister, confirming your affiliation with a recognized religious group that observes its Sabbath on Saturday or a holy day.

I observe:

❑ The Sabbath on Saturday

❑ A holy day which falls on the scheduled examination day. I will have to take the examination on another day.

Applicant: Please do not use space below. Official use only.

A. ACCOMMODATIONS REQUEST FOR EXAMINATION (check all that apply)

Time: ❑ Extra breaks/rest periods ❑ Extra testing time

Help: ❑ Reader ❑ Recorder ❑ Sign language interpreter

Other (Please explain): _____

_____

B. IDENTIFICATION

Test Date: _____

Test Location: _____

Test Form: _____

Emergency Medical Services (EMS) Systems Reasonable Accommodation Request

Name:

SS#:

Profession:

OFFICIAL USE ONLY

C. CHIEF TESTING OFFICER

Complete and forward to division head within five working days of receipt.

Recommendations: ❑ Recommended ❑ Not Recommended

Comments

Signature	Date Received	Date Forwarded

D. DIVISION HEAD

Complete and forward to reasonable accommodation chairman within five working days of receipt.

Recommendations: ❑ Recommended ❑ Not Recommended

Comments

Signature	Date Received	Date Forwarded

E. COMMITTEE

If applicable: Date returned for additional information: _____

Date received back: _____

Forward to director within 10 working days of receipt.

Signature, Coordinator	Date Received	Date Forwarded

Emergency Medical Services (EMS) Systems Reasonable Accommodation Request

Name:

SS#:

Profession:

OFFICIAL USE ONLY

F. REASONABLE ACCOMMODATION COMMITTEE

	Approve	Deny	Approve With Modifications
Program Head or Designee	❑	❑	_____
Human Resources Director or Designee	❑	❑	_____
IDPH ADA Coordinator	❑	❑	_____
Chief Fiscal Officer or Designee (as needed)	❑	❑	_____
Equal Employment or Affirmative Action Officer	❑	❑	_____
Chief Counsel or Designee	❑	❑	_____

G. REASONABLE ACCOMMODATION COMMITTEE RECOMMENDATION TO THE MEDICAL DIRECTOR

Comments

_____ Signature

_____ Date Forwarded

H. FOR MEDICAL DIRECTOR'S APPROVAL

_____ I approve the committee's recommendation.

_____ I approve the committee's recommendation as modified.

_____ Recommendation overruled.

Modifications and action ordered and reasons for overruling the recommendation:

_____ Signature, Medical Director, Office of Preparedness and Response

_____ Date Forwarded