FORM A

CANDIDATE REQUEST FOR TESTING ACCOMMODATION
(To be completed by all candidates who request testing accommodations)

NOTE: Applicants are responsible for completeness and accuracy of the information provided. Please note that it may take up to two weeks for the approval process. The evaluation and supporting documentation shall be valid for a period of five (5) years from the date on which it was submitted to FCTC. All information pertaining to your disability or medical condition is confidential and will not be divulged except as permitted or required by law.

BACKGROUND INFORMATION
(Please type or print clearly in ink)

Name: ____________________

Address: ____________________

City, State, Zip Code: ____________________

Telephone Number: ____________________

What is your diagnosed disability or medical condition(s)? ____________________

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How does the diagnosed disability or medical condition(s) affect your ability to test? ____________________

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Describe the accommodation requested. ____________________

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Have you ever received accommodations for our FCTC written test? ☐ Yes ☐ No

Past accommodations granted: ____________________

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Provide written verification of your disability from a professional described in the Policies and Procedures that supports the accommodations you are requesting. FCTC will not pay any costs you may incur in obtaining the required documentation.

Knowingly providing false information or omitting pertinent information may be grounds for denial of this application.

____________________ ____________________

Candidate's Signature **Date**

FORM B

TESTING ACCOMMODATIONS – PROFESSIONAL EVALUATOR INSTRUCTIONS

The Firefighter Candidate Testing Center (FCTC) recognizes its responsibilities under Title II of the Americans with Disabilities Act and the California Fair Employment and Housing Act (Government Code sections 12925 et seq.) to provide reasonable, appropriate and effective accommodations to qualified written test candidates with disabilities or specified medical conditions. However, these laws do not require, and FCTC will not provide, an accommodation which would do any of the following:

- Fundamentally alter the measurement of the knowledge or skills the written test is intended to test;
- Afford unfair advantage to the candidate;
- Compromise written test security;
- Propose FCTC provide personal services or devices; or
- Create an undue financial and administrative burden.

A disability is a physical or psychological disorder or condition that requires special education or related services. For more information about qualified disabilities and medical conditions, see California Government Code section 12926.

Required Qualifications for Professional Evaluators

To be considered a qualified evaluator, the professional must meet the following requirements:

1. Possesses sufficient qualifications to evaluate for the existence and nature of the disability or medical condition, and to recommend accommodations.
2. Cannot be the spouse of the candidate nor related to the candidate by blood or marriage.
3. For a **physical disability or medical condition:** the evaluator must be a licensed health care practitioner who is qualified to make the diagnosis and has expertise pertaining to the disability or medical condition.
4. For a **mental disability or diagnosis:** the evaluator must be a licensed mental health care professional who is qualified to make the diagnosis and has expertise pertaining to the disability or diagnosis.
5. For a **learning disability**: the evaluator must be one of the following:
   a. A licensed psychologist or physician who has a minimum of three (3) years of experience working with adults with learning disabilities, and who has training in all of the areas described below.

   OR

   b. Another professional who possesses a master's or doctorate degree in special education or educational psychology from a regionally accredited institution AND who has at least three (3) years of equivalent training and experience in all of the areas described below:
      - Assessing intellectual ability level and interpreting tests of such ability;
      - Screening for cultural, emotional and motivational factors;
      - Assessing achievement level; and,
      - Administering tests to measure attention and concentration, memory, language reception and expression, cognition, reading, spelling, writing, and mathematics.

Format of Examinations

Applicants are required to pass a written exam to be placed on the FCTC Statewide Eligibility List. Candidates have 2.5 hours to complete the 100 question, multiple choice test consisting of the following four sections:

- Recall and Comprehend Verbal and Visual Information. This section requires candidates to watch two short videos and answer questions based on the scenarios presented (20 questions)
- Apply Mechanical Reasoning (25 questions)
- Solve Mathematical Problems (25 questions)
- Recall and Comprehend Technical Information from Written Materials. Candidates will read a selection of essays, some of which are in a separate packet and collected (30 questions)

The test is a fully-validated general knowledge written test with questions and examples tailored to the profession and designed to demonstrate the candidate's ability to process information and think critically.

PROFESSIONAL EVALUATION AND DOCUMENTATION
OF CANDIDATE DISABILITY OR MEDICAL CONDITION
(To be completed by a physician)

NOTE: Firefighter Candidate Testing Center (FCTC) requires current documentation (within the last five years) from a physician in the field related to the applicant's disability.

PHYSICIAN INFORMATION
(Please type or print)

Name: ______________________________ Title: ______________

License/Certification Number: ______________________________

Business Name: ______________________________

Address: ______________________________

City, State, Zip Code:______________________________

Telephone Number:______________________________

Candidate's Name: ______________________________

Please complete the following <u>or</u> attach applicable documentation.

Please describe your credentials that qualify you to diagnose and/or verify the candidate's disability and to recommend an accommodation: ______________________________

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Briefly describe the nature of the condition and describe how this condition affects the candidate:

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Current treatment/date of consultation with candidate: ______________________________

Is this a permanent condition/disability? ❒ Yes ❒ No

If no, when is the condition/disability likely to abate?______________________________

In what way does the condition/disability affect the applicant's ability to read, write and/or concentrate for extended periods of time? ______________________________

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Recommended Accommodations:______________________________

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I certify that all the information on this form is true and correct to the best of my knowledge and belief. I understand this information may be reviewed by a physician retained by the administration company to assist in determining reasonable testing accommodations.

______________________________ ______________________________
Physician's Signature Date