



COUNTY OF LOS ANGELES
DEPARTMENT OF HUMAN RESOURCES
COUNTYWIDE TALENT ASSESSMENT DIVISION

REQUEST FOR REASONABLE ACCOMMODATION

THE FOLLOWING PORTION IS TO BE COMPLETED BY CANDIDATE OR AUTHORIZED REPRESENTATIVE

CANDIDATE NAME	PHONE NUMBER	TTY NUMBER
EMAIL ADDRESS		
HOME/MAILING ADDRESS		
DISABILITY (hearing, sight, mobility, etc.)		
EXAM TITLE	EXAM NUMBER	EXAM TYPE <input type="checkbox"/> DP <input type="checkbox"/> IP <input type="checkbox"/> OC
ALTERNATE CONTACT NAME	PHONE NUMBER	SOCIAL SECURITY NUMBER

Please describe the type of accommodation needed: *(Please Print)*

Candidate's Signature:

Date:

(OVER)

THE FOLLOWING PORTION IS TO BE COMPLETED BY ADA COORDINATOR

ACCOMMODATION APPROVED – ACTION TAKEN

Type(s) of accommodation provided:

Test Location:

Proctor's Name:

Test Date:

Test Time:

ACCOMMODATION DENIED – ACTION TAKEN

Reason for denial (be specific):

ADA Coordinator Name:

ADA Coordinator Signature:

Phone Number:

Date: