**Instructions**

Pre-employment exams in the County of Los Angeles are administered on the basis of fairness, merit, and equal opportunity. As such, you can receive accommodations under the Americans with Disabilities Act to fairly compete in assessments such as oral interviews, multiple choice/simulation examinations, and/or performance tests that are administered in hard copy and computerized form. We cannot provide certain accommodations that would provide an unfair advantage for one candidate over another and/or invalidate the results of the test, so it is important that you read the following instructions and complete this form to determine your eligibility for accommodations.

**Overview**

You can initiate a request for accommodations at the time you complete your job application. The process for reviewing your request is illustrated below. For further information on this page and all other sections, refer to the Appendix at the end of this form.

## **Candidate and Exam Information**

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| **First Name** | | |  | **Last Name** | | | | |  | **Neogov Applicant ID** | | |
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| **Phone Number (1)** |  | **Phone Number (2)** | | |  | **TTY Number** |  | **Email** | | | | |
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| **Exam Number** |  | **Exam Name** | | | | | | | | | | |
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1. **Test Information (TO BE COMPLETED BY THE TESTING ACCOMMODATIONS COORDINATOR)**

**Your application is currently under review to determine if you meet minimum/selection requirements. If it is determined that you meet requirements, you will be invited to take the examination. Applicants who have taken identical components recently for other exams may have their scores automatically transferred to this examination. You will receive notification if you meet the requirements and if you have transferrable scores. This form is being provided to you in order to give you time before the test administration to provide any necessary documentation, if needed. Review the information on the test below, and complete the next two sections if you will need accommodations.**

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| **Date of Completion** | |  | | **Completed By** | | | |
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|  | |  | |  | | | |
| **Test Part** |  | |  | |  |  |  |
| Type of Test |  | |  | |  |  |  |
| Mode of Administration |  | |  | |  |  |  |
| Number of Questions |  | |  | |  |  |  |
| Time Limit |  | |  | |  |  |  |
| In Office, On Location, or Remote |  | |  | |  |  |  |

## **Breaks may be provided between test parts. Contact** [**testingaccommodations@hr.lacounty.gov**](mailto:testingaccommodations@hr.lacounty.gov) **to inquire.**

1. **Accommodation Request (TO BE COMPLETED BY THE CANDIDATE): CANDIDATE TO COMPLETE SECTION III AND SUBMIT SECTION IV TO THE QUALIFIED MEDICAL PROVIDER/OTHER QUALIFIED PROFESSIONAL.**

Based on the Test Information above, please identify which of the following types of accommodations you are requesting.

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| --- | --- | --- |
| **Choose Test Part** |  | **Choose Test Part** |
| **Timing and Scheduling** |  | **Timing and Scheduling** |
| Time and a Half |  | Time and a Half |
| Double Time |  | Double Time |
| Breaks: # of Breaks       Length |  | Breaks: # of Breaks       Length |
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|  |  |  |  |
| Other (describe accommodation request below) |  | Other (describe accommodation request below) |
|  |  |  |

1. **Supporting Documentation OR Qualified Medical Provider/Other Qualified Professional: AFTER COMPLETING THIS SECTION, THE CANDIDATE MUST RETURN FORM TO testingaccommodations@hr.lacounty.gov WITHIN TEN (10) BUSINESS DAYS FROM THE RECEIPT OF THIS FORM.**

A. Supporting Documentation – I have previously filed documentation with the Department of Human Resources and my condition has not changed.

B. Qualified Medical Provider/Other Qualified Professional Information – I am requesting my Qualified Medical Provider’s/Other Qualified Professional’s Information to support my requested testing accommodations. (TO BE COMPLETED ON THE NEXT PAGE BY THE QUALIFIED MEDICAL PROVIDER/OTHER QUALIFIED PROFESSIONAL)

**Instructions for Qualified Medical Provider/Other Qualified Professional**

Please review the applicant’s medical or educational history as appropriate, instructions and information in this form, and any testing accommodations requested by the candidate. If you support the candidate’s request for the reasonable accommodation(s), please complete the information below and return the form to the applicant. If you would prefer to submit a memo or professional letter in lieu of completing this form, it **MUST** include all information requested below in order to be considered. Note, we cannot provide certain accommodations that would provide a candidate with an unfair advantage and/or invalidate the results of the test (e.g., removing the time limit from a test that is intended to measure a candidate’s ability to respond to questions under time constraints).

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| **Name of Qualified Medical Provider/Other Qualified Professional** | | | | |  | |
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| **Phone Number** |  | **Fax** | | | | |  | | **Email** | | | | | | | | | |
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| **Address** | | | | | | | | | | | |  | **State** | |  | **Zip Code** | |
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| **Occupation/Title/Specialty** | | | | | |  | **License Number/Certification** | | | | | | | | | | |
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| **Organization/Agency/Employer** | | | | | |  | **Licensing Agency** | | | | | | | | | | |
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| **Accommodation Recommendation** | | | | | | | | | | | | | | | | | |
| I certify that the above-named candidate has a disability and/or condition as defined by the California Fair Employment and Housing Act and/or Americans with Disabilities Act. Consequently, I recommend that the following Testing Accommodation(s) be provided to this individual during the exam. | | | | | | | | | | | | | | | | | |
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| **Please provide a description of how the candidate’s condition impacts their ability to participate in the standardized testing process. Please do not disclose diagnosis.** | | | | | | | | | | | | | | | | | |
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| Qualified Medical Provider/Other Qualified Professional Signature | | | | | | | | | |  | Date | | | | | |

**Confirmation of Accommodations Provided**

**To Be Completed by the Testing Accommodations Coordinator**: Please review the candidate’s request for testing accommodation and any supporting documentation and determine the status of the request accommodation:

Approved – The requested accommodations are approved.

Alternative reasonable accommodations are approved

Denied – insufficient information to support the need for testing accommodations.

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| **The following testing accommodations will be provided** |
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**Appendix**

## **Candidate and Exam Information**: You can request accommodations via the supplemental questionnaire when filing an application. Information from the application will be used to populate the Candidate and Exam Information Section of this form. You may still request accommodations after filing an application by completing this section and submitting it to [testingaccommodations@hr.lacounty.gov](mailto:testingaccommodations@hr.lacounty.gov). However, we cannot guarantee that you will be considered for the first phase of hiring. If you begin the test prior to submitting a request and/or receiving a decision for accommodation, we will not be able to consider your accommodation request since you will have been exposed to test material.

1. **Test Information**: Upon receipt of your request for accommodations, our Testing Accommodations Coordinator will populate the Test Information section and return this form to you. This section is designed to help you understand our assessment process and aid in your completion of Section III, Accommodation Request.
2. **Accommodation Request**: Please review the Test Information section and select the requested accommodation.
3. **Supporting Documentation OR Qualified Medical Provider/Other Qualified Professional**:Pre-employment exams in the County of Los Angeles are administered on the basis of fairness, merit, and equal opportunity. As such, you can receive accommodations under the Americans with Disabilities Act to fairly compete against other job candidates. However, we cannot provide certain accommodations that would provide an unfair advantage and/or invalidate the results of the test.

You must submit supporting documentation in part A of this section, **OR** have your **Qualified Medical Provider/Other Qualified Professional** complete part B of this section within **ten (10) business days of receiving this form** in order to be considered for the first phase of hiring. Please submit the entire document to the Testing Accommodations Coordinator at [testingaccommodations@hr.lacounty.gov](mailto:testingaccommodations@hr.lacounty.gov) for final review.

* 1. **Supporting Documentation *(to be submitted by candidate)***: Please indicate if you have already provided documentation in previous requests that illustrates your current condition. Otherwise, provide new documentation supporting the requested accommodation in part B of this section. This may include, but not limited to: Individual Education Plans (IEPs), 504 plans, or other official documentation demonstrating the need for accommodation(s) under the Americans with Disabilities Act.
     + We only need information demonstrating support for an accommodation and do not need you to disclose information pertaining to your disability.
     + If we determine there is insufficient information to process your request, we will send this form back and ask for supporting documentation from your Qualified Medical Provider/Other Qualified Professional, below.
  2. **Qualified Medical Provider/Other Qualified Professional Information *(to be completed by the Qualified Medical Provider/Other Qualified Professional)***:Please review the test information and accommodation requested by the job candidate in Section III, Accommodation Request. Answer the questions in this section and recommend the accommodation the candidate would need to fairly compete in the exam.

1. **Confirmation of Accommodation Request**: Following final review of this form, the Testing Accommodations Coordinator will document the type of accommodations being offered and return this form to the candidate.