



Dear Candidate,

To apply for Reasonable Testing Accommodation for one or both of your Cosmetology tests, you must fill out the attached forms and submit them by mail to the Washington State Department of Licensing.

DOL will accept or deny all requests for Reasonable Testing Accommodation. They will inform the student of their decision in writing.

Please follow these steps:

- Do not schedule your test, your accommodations must be approved before you can schedule your test
- Fill in these forms completely and mail them to DOL at the address below
- DOL will inform you of their decision
- When you have DOL approval, schedule your test

When you have completed the forms mail them to this address:

Department of Licensing
Cosmetology Unit
PO Box 9048
Olympia WA 98507-9048

All sections of the form must be completed; if one of the forms does not apply, please complete it as “*not applicable*”.

DOL will inform you of their decision
When you have DOL approval, schedule your test

Best regards,

National Testing Network
Cosmetology Testing in Washington State
www.CosmetologyWashington.com

FORM A

REASONABLE TESTING ACCOMMODATIONS QUESTIONNAIRE (To be completed by all applicants who request reasonable testing accommodations)

NOTE: Applicants are responsible for completeness and accuracy of the information provided. If you are requesting a reasonable testing accommodation, the following forms must be completed and returned with your Scheduling Request Form.

(Please type or print)

Background Information

Applicant Name: _____

Address, City, State & Zip: _____

Telephone Number: _____

Nature of disability (Check all that apply):

_____ Hearing impaired

_____ Specific learning disability

_____ Other physical disability

_____ Chronic health problem

_____ Psychological disability

_____ Temporary accidental injury

_____ Other _____

Describe the nature and extent of your disability.

How long have you had your disability?

_____ 1 to 3 years

_____ 5 years or more

_____ Most of my life

Past Accommodations Granted:

	YES	NO
Were you in a specific school or program to accommodate your disability?	_____	_____
Did you receive accommodations for classroom tests?	_____	_____
Did you receive additional testing time for classroom tests?	_____	_____

Please describe any additional accommodations you were granted while in school. _____

Requested Accommodations:

Use of a reader

Written Exam

Practical Exam

Rest period

_____ N/A _____

Additional testing time for each test session.

Other accommodations requested (please specify below)

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.

Applicant's Signature

Date

FORM B

REASONABLE TESTING ACCOMMODATIONS – DISABILITY DOCUMENTATION (To be completed by a physician)

NOTE: The Cosmetology Section, requires current documentation (within the last three years) from a physician in the field related to the applicant's disability. Applicant must also submit previous evaluation documentation of disability for review (e.g. IEP, PET etc.).

Physician:

Name: _____ Title _____

License/Certification Number: _____

Address: _____

Telephone Number: _____

RE: Applicant Name: _____

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

Briefly describe the nature of the condition and describe how this condition affects the applicant.

Current treatment consisted of: _____

Last date of treatment-date of consultation with applicant: _____

Length of treatment with applicant: _____

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? _____

Based on this person's disability and your diagnosis, what testing accommodations would you recommend?
(Check all that would apply.)

Requested Accommodations:	Written Exam	Practical Exam
Use of a reader	_____	_____ N/A
Rest period	_____	_____
Additional testing time for each test session.	_____	_____
Other accommodations requested (please specify below)	_____	_____

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.

Signature of Physician

Date

