Wisconsin Department of Safety and Professional Services

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OFFICE OF EDUCATION AND EXAMINATIONS

PROFESSIONAL VERIFICATION OF REQUEST FOR TRADE EXAM MODIFICATION

This form is intended to be filled out by a professional on behalf of an exam candidate seeking exam modifications. **Please note that a signature of the candidate is required at the bottom of the form on Page 2.**

Trade Credential Applied for: _____

_____ __/__/____, a candidate for

(Candidate Full Name) **(Candidate Date of Birth)**

examination by the Wisconsin Department of Safety and Professional Services has made a request for modification of examination based on a disability of the candidate.

The purpose of this form is to request your professional opinion concerning the disability and the modification requested. Please answer the questions below and sign the certification. The opinion you provide will be used in evaluating the request.

The information obtained on this form will be treated as a medical record except that exam proctors and exam providers may be informed regarding necessary modifications to exam procedures, and first aid and safety personnel may be informed, when appropriate, if the disability might require emergency treatment.

PROFESSIONAL VERIFICATION - MUST be completed by the professional evaluator, NOT the applicant.

Please respond to the following questions regarding the above-mentioned individual. Use additional sheets where necessary. Previously prepared diagnostic reports may be submitted if all questions below are answered by the report.

1. **What is the specific diagnosis of the disability?**

2. **On what date did you make this diagnosis?** (mm/dd/yyyy) __/__/____

3. **What are your specific recommendations for test modifications? For example, additional time (time and a half or double time), a private room, extra breaks, or a reader, etc. Please be specific.**

Continued on Page 2.

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PROFESSIONAL VERIFICATION - continued from Page 1.

I certify that I have the necessary specialized training to make the above diagnosis, that I personally examined the candidate named above, and that the diagnosis and assessment of modification request described above is my professional judgment. I understand that the Department may contact me (with the candidate's permission) to obtain further information, if necessary, and that the Department may obtain an independent assessment by a second professional.

Signature of Professional (Print and Sign Form)

Name of Institution or Practice

Typed or Printed Name of Professional

Street Address

Title

City

State

Zip Code

Telephone Number (include area code)

Ext

Signature Date for Professional (mm/dd/yyyy)

CANDIDATE: I give the Department of Safety and Professional Services permission to contact the above professional and discuss the findings of this report.

Signature of Candidate (Print and Sign Form)

Signature Date (mm/dd/yyyy)

Questions about this form or the Department policy for the accommodation of disabilities may be addressed to the Office of Examinations, (608) 266-2112, or DSPSCourseApproval@wisconsin.gov.

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