The information requested below and any documentation regarding your disability and your need for an accommodation in testing/interviewing will be considered strictly confidential.

Please print all information

Applicant Name: _____

Date of Request: _____

Address: _____

Telephone #: _____ cell # _____

Position Applied For: _____

Accommodation(s) requested for the _____ examination/interview.
Check all that apply:

_____ Accessible testing/interview site
_____ Braille _____ Large Print _____ Audio Tape
_____ Reader
_____ Scribe
_____ ASL Sign Language Interpreter
_____ Extended Time
_____ Time-and-a-half
_____ Double time
_____ More than double time (Specify):_____
_____ Separate testing area
_____ Use of a computer or other adaptive equipment (Specify):
_____
_____

Signature of Applicant _____
Date _____
Signature of ADA Coordinator _____
Date _____

Additional Comments:
Some accommodation requests will require documentation of disability. See the next page of this form.

Information on this form shall be confidential with exceptions according to the Rehabilitation Act of 1973, Section 504, Subd. 84.14, and the Americans with Disabilities Act of 1990, Subd. P.L. 101-336, Sec 102 C. the Americans with Disabilities Restoration Act of 2008.

Testing Accommodation
Documentation of Disability-Related Need

If you have a learning disability, psychological disability or other invisible disability that requires an accommodation in testing, please have this section completed by an appropriate professional (education professional, doctor, psychologist, psychiatrist, vocational rehabilitation professional) to certify that your disability requires the requested testing accommodation.

If you have existing documentation of having the same or similar accommodation(s) provided to you in another testing situation, you may submit such documentation instead of having this portion of the form completed.

I have known _____ since _____ in my
(Applicant's Name) (Date)

capacity as a _____.
(Professional Title)

The applicant has discussed with me the nature of the test to be administered. It is my professional opinion that because of this applicant's disability he/she should be accommodated by providing the following: (check all that apply)

Accommodation(s) requested for the _____ examination/interview.
(Position)

Check all that apply:
_____ Accessible testing/interview site
_____ Braille _____ Large Print _____ Audio Tape
_____ Reader
_____ Scribe
_____ ASL Sign Language Interpreter
_____ Extended Time
_____ Time-and-a-half
_____ Double time
_____ More than double time (Specify):_____
_____ Separate testing area
_____ Use of a computer or other adaptive equipment (Specify):
_____

Signed: _____ Date: _____
Title: _____ License # (if applicable): _____

Submit these forms with your application for employment to City of Las Cruces Human Resources Department, 700 N. Main St., Las Cruces, NM 88001 or fax to 575-528-3020.