Human Resources Management Department

Lionel J. Wilson Building
150 Frank H. Ogawa Plaza, Suite 2352
Oakland, CA 94612

Phone (510) 238-3112
Fax (510) 238-2325
TDD (510) 238-3254

REQUEST FOR REASONABLE ACCOMMODATION IN TESTING

To request a reasonable accommodation for an examination, please complete the following form and submit it, along with medical certification from a health care provider (attached), to the Human Resources Management Department prior to the examination. If the accommodation request involves wheelchair access or sitting in the front of the room, it is not necessary to complete this form or advise the Human Resources Management staff in advance of the examination.

NAME: ____ EMAIL: ______________________________________
(Last, First Middle)

ADDRESS: ____

CITY: __________________________ STATE: _____ ZIP CODE: ________

TELEPHONE #: __________________ ______________________
(Primary) (Secondary)

POSITION APPLIED FOR: ____
(Classification Title)

Please respond to the following:

My disability impairs my ability to accurately exhibit my knowledge and skill on the examination in the following manner:

The reasonable accommodation(s) I am requesting is: (Select apply that apply)

- ☐ Separate testing area (This is required if there will be verbalization either by the applicant or by the reader/recorder.)
- ☐ Sign language interpreter
- ☐ Large print materials
- ☐ Written instructions as accommodation for hearing impairment
- ☐ Reader
- ☐ Scribe
- ☐ Specified breaks during testing (Also available for lactating mothers)
- ☐ Additional Testing Time (Specify)
- ☐ Special Chair/Table (Specify)
- ☐ Special Lighting (Specify)
- ☐ Other (Specify)

COMMENTS:

CITY OF OAKLAND

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I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct. I certify that I agree to the modified testing condition(s) authorized by the City and I will not discuss the exam content with anyone other than authorized representatives of the City. I give permission for the City to contact my health care provider to verify my need for testing accommodations or to discuss my work restrictions, if necessary.

_________________________________ _________________________________
Applicant Signature Date

Applicant's Health Care Provider Certification

To: Employee's Personal Physician
From: Human Resources Management Department
Via: Your Patient
Re: Patient's Request For Reasonable Accommodations in Testing

Your patient is in the process of requesting reasonable accommodations from the City of Oakland to assist them in testing for a position for which they have applied. They have requested testing accommodations as listed earlier on this form to reasonably accommodate their disability. To support the City of Oakland to consider this request, and in compliance with the Fair Employment and Housing Act (Government Code § 12940) and Title I of the Americans with Disabilities Act (42 U.S.C. § 12101, et seq.), your assistance is requested to provide information in support of this request. Please answer the following questions and provide the completed questionnaire to your patient, who will return it, with their full application request for accommodations to the City.

Physician's Name: ________________________ **License Number:** ________________

Physician's Phone Number: ________________________ **Date of Examination:** ________________

I have reviewed my patient's request for testing accommodations and can certify: (please check the appropriate box)

☐ **I support my patient's request for testing** reasonable accommodation(s) as these will enable my patient to complete the City of Oakland's employment examination process. I certify that this patient has a physical or mental impairment that would limit their ability to otherwise participate equally in this testing process without these accommodations in place.
☐ **I cannot support my patient's request for testing**; I am unaware of their need for testing accommodations.
☐ **Other / Additional Information:**

____
Health Care Provider's Signature Date

Please return this completed form to your patient.