



REQUEST FOR SPECIAL ACCOMMODATION DURING ADMINISTRATION OF WRITTEN BAR LICENSING EXAMINATION

In compliance with the American with Disabilities Act (ADA), the Bureau of Automotive Repair (BAR) provides "reasonable accommodation" for applicants with disabilities that may affect their ability to take required examinations. Accommodations provided for difficulties reading/understanding English are provided only when a disability is diagnosed by a licensed medical professional, as described in Section C.

It is the applicant's responsibility to notify BAR of the accommodation(s) desired. We are not required to provide alternative arrangements if we are not aware of your needs. All requests will be considered on a case by case basis. You will receive written confirmation once all requirements have been met. The information requested on this form and any documentation regarding your disability will be considered strictly confidential.

Before an exam can be scheduled with the accommodations that you have requested, you must complete form BAR-117 (Request for Special Accommodation During Administration of Written BAR Licensing Examination), provide supporting professional verifications as necessary, and if applicable, provide proof of past modifications, accommodations, auxiliary aids, or services received by you in similar testing situations, as well as modifications, accommodations, or related aids and services provided to you in response to an Individualized Education Program (IEP) provided under the Individuals with Disabilities Education Act or a plan describing services provided to you pursuant to section 504 of the Rehabilitation Act of 1973 (a section 504 plan). All relevant documents must be submitted to the Licensing Unit. BAR will not pay any costs you may incur in obtaining the required documentation. However, BAR will pay for any reasonable accommodations that are made for you at the examination site.

NOTICE ON COLLECTION OF PERSONAL INFORMATION

COLLECTION AND USE OF PERSONAL INFORMATION

BAR and DCA use the personal information requested on this form to identify and evaluate applicants for licensure, issue and renew licenses, and enforce licensing standards set by law and regulation. BAR is authorized to collect this information by Business and Professions Code sections 30, 9884, and 9887.2, Labor Code section 432.7, Civil Code section 1798 et seq. (Information Practices Act), and California Code of Regulations, title 16, section 3306. Pursuant to Business and Professions Code section 27, the address of record is a public record and will be posted on BAR's website.

POSSIBLE DISCLOSURE OF PERSONAL INFORMATION

BAR and DCA make every effort to protect personal information provided. However, the information provided may be disclosed in the following circumstances: in response to a Public Records Act request (Government Code section 6250 et seq.), as allowed by the Information Practices Act (Civil Code section 1798 et seq.); to another government agency as required by State or Federal law; or, in response to a court or administrative order, a subpoena, or a search warrant.

Effective July 1, 2012, the State Board of Equalization and the Franchise Tax Board may share taxpayer information with this agency. Your license may be suspended by BAR if your state tax obligation is not paid.

ACCESS TO PERSONAL INFORMATION

Pursuant to California Civil Code section 1798 et seq. (Information Practices Act), the Director of DCA is responsible for maintaining the information on this application. Individuals have the right to review the records maintained on them by the agencies, unless the records are exempt by California Civil Code section 1798.40.

CONTACT INFORMATION

For questions about this notice or access to your records, you may contact the Bureau of Automotive Repair Licensing Unit at 10949 North Mather Boulevard, Rancho Cordova, CA 95670 or by phone at (855) 735-0462. For questions about the department's Privacy Policy, you may contact the Department of Consumer Affairs at 1625 North Market Boulevard, Sacramento, CA 95834, by phone at (800) 952-5210, or by email at dca@dca.ca.gov. For questions about the Information Practices Act, you may contact the Office of the Attorney General, California Department of Justice - Attention: Public Inquiry Unit, P.O. Box 944255, Sacramento, CA 94244, Toll Free (800) 952-5225, www.oag.ca.gov.



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SECTION A. APPLICANT INFORMATION		
APPLICANT NAME	PHONE NUMBER	
ADDRESS Number and Street		
CITY	STATE	ZIP CODE
MY DISABILITY IS:		
MY DISABILITY IMPAIRS MY ABILITY TO ACCURATELY EXHIBIT KNOWLEDGE AND SKILL ON THE EXAMINATION IN THE FOLLOWING MANNER		
SECTION B. REQUESTED ACCOMMODATION		
Select from the accommodations listed below. If your request is limited to wheelchair access, professional verification and a medical release <u>are not required</u> . Complete Section D, print, sign and date this form, and return it to the above address. For all other requests, professional verification and a medical release <u>are required</u> . Complete Sections C and D, print, sign and date this form, and return it along with the medical verification and release to the above address.		
WHEELCHAIR ACCESS	LARGE PRINT EXAM	
WRITTEN INSTRUCTION AS ACCOMMODATION FOR HEARING IMPAIRMENT	SCRIBE AS ACCOMMODATION FOR VISUAL OR MOTOR IMPAIRMENT	
OTHER - DESCRIBE:		
SECTION C. MEDICAL VERIFICATION		
Step 1. Complete the medical release (page 3). Step 2. Submit the completed medical release with a request to your licensed medical or psychological professional for a professional verification letter of your disability. The verification letter must be submitted on letterhead stationary of the medical or psychological professional and include: <ul style="list-style-type: none"> The history, nature, and extent of the disability as well as the tests performed to diagnose the disability. The effect of the disability on your ability to perform under normal testing conditions. Specific special accommodations for the multiple-choice written examination the medical or psychological professional recommends and how that accommodation relates to your disability. Name, title, telephone number, and professional license or certification number of the medical or psychological professional. Description of professional training and experience the medical or psychological professional has with this type of disability. They must have appropriate education and experience in evaluating your type of disability and state their qualifications. Step 3. Submit the professional verification letter with original signatures, medical release, and this form to the address listed above.		
SECTION D. APPLICANT CERTIFICATION		
I certify under penalty of perjury of the laws of the State of California that the foregoing statements and those in any required accompanying documents or statements are true. I understand that false information may be cause for denial or loss of license and that BAR may obtain an independent assessment of my disability described on this form by a second professional at BAR expense.		
SIGNATURE (please sign in ink)	DATE	

HIPAA - COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the use and/or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary.

PATIENT NAME	DATE OF BIRTH
PERSONS/ORGANIZATIONS AUTHORIZED TO PROVIDE THE INFORMATION	

California Department of Consumer Affairs, Bureau of Automotive Repair ("Bureau") Licensing Unit, P.O. Box 989001, West Sacramento, CA 95798-9001, is authorized to receive and use the information in connection with my request for licensing testing accommodations. I further authorize that a photocopy of this medical release may be used by the Bureau to order and obtain medical information.

Specific description of information: complete medical record for all dates of service and all admissions including, but not limited to: history and physical exam; progress notes; office notes and letters; office chart; laboratory reports; diagnostic test reports including, but not limited to, x-ray, MRI, CT scan, bone scan, thermography reports; inpatient admissions and discharge reports; outpatient and emergency room admissions; complete hospital chart; healthcare records in your file from other providers; prescription records; operative reports; physical therapy.

The purpose of use or disclosure of patient information is for my request for licensing testing accommodations. Patient information may be used to determine my eligibility for special accommodation. Patient information may not be re-disclosed to any one for any purpose.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, revocation will not affect any actions the provider took before it received the revocation. Also, I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by a revocation.

I understand that I may refuse to sign this form but that my eligibility for special testing accommodation will be affected if I do not sign this form.

I understand that I am entitled to receive a copy of this authorization.

SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE		DATE
ADDRESS Number and Street		
CITY	STATE	ZIP CODE
IF A PATIENT'S REPRESENTATIVE SIGNS THIS AUTHORIZATION, PLEASE COMPLETE THE FOLLOWING		
PRINTED NAME OF PATIENT'S REPRESENTATIVE		RELATIONSHIP TO PATIENT
DESCRIBE THE REPRESENTATIVE'S AUTHORITY TO ACT FOR THE PATIENT		