Circular C-039
ATTACHMENT 1
Health and Human Services System

Reasonable Modification Request for Licensing or Certification Examinations

With a few exceptions, you have the right to request and be informed about the information that the agency obtains about you. You are entitled to receive and review the information upon request. You also have the right to ask the agency to correct information that is determined to be incorrect (Government Code, Sections 552.021, 552.023, 559.004).

Section I. *To be completed by the applicant and sent to the licensing or certification program.*

Name of Applicant	Address of Applicant	
Telephone Number of Applicant ( )	E-mail Address of Applicant	
Name of License or Certification	Name of HHS Agency	Name of Licensing or Certification Program
Date of Next Exam or Other Licensing/Certification Process		Telephone Number of Program ( )

Please identify the disability which affects your ability to take the licensing or certification exam:
(Check All That Apply)

- ☐ Visual Impairment
- ☐ Mental or Emotional Impairment
- ☐ Orthopedic (mobility or functional impairment or missing extremity)
- ☐ Deafness or Hearing Impairment
- ☐ Dyslexia or Other Learning Disability
- ☐ Other (specify):

A disability is physical or mental impairment that substantially limits one or more major life activities. Explain how your disability affects your ability to participate in the certification or licensing examination process:

Modification(s) Requested:

- ☐ Extended Time
- ☐ Separate Testing Room
- ☐ Reader
- ☐ Zoom Text or Large Print
- ☐ Paper and Pencil Examination
- ☐ Other (specify):

Please attach supporting medical or other diagnostic information to this form.

Send proof of your disability on letterhead stationery from a medical doctor or other professional, the Department of Assistive and Rehabilitative Services, or a school. The diagnosis must be dated no earlier than three years before the date of this request for reasonable modification. You are not required to give documentation for an obvious disability unless you need to explain how the disability relates to the modification(s) you are requesting. You may be asked to sign a Documentation and Release of Information form.

Signature of Applicant	Date

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Section II. *To be completed by the licensing or certification program. Upon completion of Sections I and II by the responsible parties, the program shall send this form to the HHSC Civil Rights Office.*		
Comments/Recommendation:		
Name of Program Manager	Address	Telephone Number ( )
E-mail Address of Program Manager		
Signature of Program Manager		Date
Section III. *To be completed and retained by the Civil Rights Office. The Civil Rights Office shall send a copy to the applicant and program manager.*		
Assigned to:		
Modification(s) Granted ☐ Yes ☐ No		
Modification(s) (Check All That Apply) ☐ Testing Period Modified ☐ Facilities Modified ☐ Other (specify):		
Below, describe the modification(s) in detail. If the Civil Rights Office closed the case, give the reason. If the modification(s) would cause undue hardship or fundamentally alter the nature of the program, explain how.		
Signature of Civil Rights Office Assistant Director or Designee		Date

HHSC Civil Rights Office: Phone (888) 388-6332; Fax (512) 438-5885; TTY (877) 432-7232;
Email hhscivilrightsoffice@hhsc.state.tx.us