# ACCOMMODATION QUESTIONNAIRE
## OFFICE OF ATTORNEY GENERAL
## BUREAU OF CRIMINAL INVESTIGATION
SFN59653 (10/2010)

Use this form to request reasonable accommodations required to successfully complete Class 1 firearms permit testing.

**Section 1: To be completed by applicant**

| Name of Applicant | | Date |
|---|---|---|
| Mailing Address | | |
| City | State | ZIP Code |
| Describe your disability and explain how it impacts daily major life functions. Describe what you are unable to do in your everyday life because of your disability. | | |
| State how your disability impacts your ability to handle a firearm or to complete the required Class 1 course of testing (i.e., standing, balancing, walking, handling a firearm). Also, list the use and the amount of physical dependency on any type of prescribed ambulatory devices (crutches, canes, wheelchair, etc.). | | |
| What accommodation are you requesting? | | |

I hereby grant the North Dakota Bureau of Criminal Investigation permission to obtain my medical information for the purpose of determining my eligibility. I also certify the information provided on this application is true and accurate.

| Signature of Applicant | Date |
|---|---|
| | |

**Section 2: Medical Provider Statement** (A licensed physician or healthcare provider must complete the following section)

Name of Physician or Healthcare Provider

Name of Applicant

Healthcare Provider: This applicant has applied for a Class 1 firearm permit. In order to obtain this permit, the applicant must successfully complete a course of fire. This requires the applicant to be able to load/reload, carry, holster/unholster, operate, draw, support, shoot in supported and unsupported positions, stand and kneel and transition between. This applicant has requested an accommodation due to disability. In order to help us determine which accommodations are necessary and reasonable, we ask you to complete this questionnaire and return it to your patient. The questionnaire format is a guide and we would appreciate a response to every question. We need your complete medical opinion, so please feel free to include a more detailed narrative response to any and all questions if needed to answer more fully. Thank you for your anticipated cooperation.

IMPORTANT NOTE TO HEALTHCARE PROVIDER

When answering these questions, please do not take into consideration any ameliorative effects of mitigating measures, such as medications, medical supplies, equipment, or appliances, low-vision devices (which do not include ordinary eyeglasses or contact lenses), prosthetics, including limbs and devices, hearing aids and cochlear implants or other implantable hearing devices, mobility devices, or oxygen therapy equipment and supplies; use of assistive technology; reasonable accommodations or auxiliary aids or services; or learned behavioral or adaptive neurological modifications.

Does this applicant have a physical or mental impairment?

☐ Yes ☐ No

If yes, please state the type of impairment.

Does this impairment substantially limit major life activities? Some examples of major life activities include, but are not limited to: seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, caring for oneself, and performing manual tasks.

☐ Yes ☐ No

If yes, which major life activity or activities are limited?

Is the disability permanent?

☐ Yes ☐ No

If no, what is the expected duration of the disability?

Describe to what extent the patient's disability impacts his/her ability to safely handle a firearm for example: standing, walking, grip strength, finger/hand coordination, strength and range of motion of arms and shoulders, etc.

Please describe any accommodations that would allow this patient to be able to safely complete the firearm Class 1 testing and to safely handle a firearm.

Would handling a firearm result in a direct safety or health threat to this patient or to other people?

☐ Yes ☐ No

If yes, please describe what threat would be posted, and advise what reasonable accommodations may be made to eliminate the direct safety or health threat, or reduce it to an acceptable level.

| Name of Healthcare Provider | Title | |
|---|---|---|
| Mailing Address | | |
| City | State | ZIP Code |
| Signature of Healthcare Provider | Date | |