Petition for Testing Accommodations

Form A

To be completed by Applicant

(Please type or legibly print.)

<table>
<thead>
<tr>
<th>Applicant Name:</th>
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<th>Address:</th>
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<th>Day Time Phone:</th>
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<table>
<thead>
<tr>
<th>Social Security Number:</th>
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<tr>
<th>Date of Exam You Are Seeking Accommodations:</th>
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<td>Month: Year:</td>
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1. Describe the physical or mental impairment that is the basis for your request for testing accommodations and explain the impact of this impairment on your ability to take the Bar Examination under standard testing conditions. Be as specific as possible.

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

2. Provide the date on which you became disabled: ____________________________

3. On the next page, list the names, professional titles, addresses, and telephone numbers of medical and psychological authorities with whom you have sought assessment and/or treatment for your physical or mental impairment, and include the dates of assessment and/or treatment for each medical or psychological authority. The names listed should be the providers who will be providing a Certificate of Medical or Psychological Authority.

FORM A
4. Describe, in detail, any accommodations you have received for your physical or mental impairment in academic, testing or employment settings. (Provide a Certificate of Accommodations from each employer and/or educational institution.)

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

5. State the testing accommodations you request and explain how the testing accommodation relates to your physical or mental impairment. **Be as specific as possible.**

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

TO BE COMPLETED BY APPLICANT

I swear or affirm that all the information on this form is true and correct to the best of my knowledge, and I understand that it may be reviewed by a physician or other licensed professional.

___________________________________________________ ________________________
Applicant’s Signature Date
CERTIFICATE OF MEDICAL/PSYCHOLOGICAL AUTHORITY

FORM B

This section to be completed by Applicant
Please type or legibly print.

Applicant's Name:_______________________________________________

Social Security Number:__________________________________________

Address:____________________________________________________________________________________

____________________________________________________________________________________

Telephone Number:__________________________________________________________________________

NOTE TO APPLICANT:
Your Petition for Accommodations WILL NOT be considered if Form B is not completed by the Provider and returned to the Office of Bar Admissions by the posted deadline.

This section to be completed by Physician, Psychologist, or Professional licensed to diagnose and treat Applicant's impairment

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<tr>
<th>Name:</th>
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<tbody>
<tr>
<td>Title:</td>
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<tr>
<td>Address:</td>
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<td>Phone:</td>
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</table>

1. Describe your professional qualifications (terminal degree, clinical speciality, licensure, etc.) that enable you to act in the capacity of medical or psychological authority on the Applicant's physical or mental impairment. **A recent copy of your curriculum vitae must be attached.**

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
2. State the date(s) on which you have examined the Applicant.

________________________________________________________________________
________________________________________________________________________

3. Describe the nature and severity of the Applicant's physical or mental impairment and discuss its effect on the ability of the Applicant to complete the Bar Examination under standard administration procedures.

(The Georgia Bar Examination is a two-day examination. The first day consists of four essay questions, two forty-five-minute questions answered in the morning session and two in the afternoon session, and two ninety-minute performance tests, one in the morning and one in the afternoon. The second day is a two-hundred-question, timed, multiple choice examination answered in pencil on a computer-graded grid sheet; one hundred questions are answered in the three-hour morning session, the same for the afternoon session.)

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

4. List the complete ICD (International Classification of Diseases), diagnosis of the physical impairment or the complete multi axial DSM-IV (Diagnostic and Statistical Manual of Mental Disorders) diagnosis of mental impairment. Include all relevant severity and course specifiers.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

5. List the studies and/or procedures used to diagnose the physical or mental impairment and attach a copy of all pertinent medical or psychological records, including results of laboratory studies, diagnostic tests, and clinical procedures used to determine presence and severity of the impairment. In the case of psychological and psycho educational testing, please attach all raw data and psychological reports pertinent to impairment.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
6. State the testing accommodations you recommend for the Applicant and explain how the testing accommodations relate to the Applicant's physical or mental impairment. If your recommendations for testing accommodations include an extension of the customary examination time, describe your rationale for the amount of time recommended.

***************

TO BE COMPLETED BY THE PROVIDER:

I certify that all the information is true and correct to the best of my knowledge and belief.

_________________________________________  ____________________________
Provider's Signature                        Date

FORM B
CERTIFICATE OF ACCOMMODATIONS

FORM C

To be completed by the appropriate school, employment or testing official regarding the Applicant named below

<table>
<thead>
<tr>
<th>APPLICANT NAME:</th>
<th>SSN #:</th>
</tr>
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</table>

1. List your name, position, name of the educational institution (or name of company or other employer), address and telephone number.

   Name & Position: ____________________________________________________________

   Educational Institution/Company: ____________________________________________

   Address: __________________________________________________________________

   Phone: ___________________________________________________________________

2. Name the course of study and the dates in which the Applicant was enrolled at your educational institution (or name the Applicant’s position and dates of employment).

   ________________________________________________

   ________________________________________________

   ________________________________________________

3. If the Applicant received accommodations, state the nature of the physical or mental impairment of the Applicant that served as a basis for granting accommodations.

   ________________________________________________

   ________________________________________________

4. Specifically describe the accommodations granted to the Applicant.

   ________________________________________________

   ________________________________________________
NOTICE TO SCHOOL, EMPLOYMENT OR TESTING OFFICIAL:
Attach a copy of any documentation that was used in making a decision regarding accommodations for this Applicant.

_______________________________________________ ____________________________
Signature Date

NOTE TO APPLICANT:
You MUST copy and complete FORM C as many times as necessary to send to each school, testing entity, or workplace where you received accommodations.

FORM C
AUTHORIZATION FOR RELEASE OF INFORMATION

FORM D
To be completed by Applicant

Authorization to Release and Exchange Information
between
Supreme Court of Georgia
Office of Bar Admissions
Board of Bar Examiners
244 Washington Street, SW - Suite 440
Atlanta, GA 30334
(404) 656-6340

(including the Board’s Medical and Psychological Consultants)

and

____________________________________________________________________________
(Provider)

____________________________________________________________________________
(Address)

____________________________________________________________________________
(Telephone No.) (Fax No.)

REGARDING

____________________________________________________________________________
Name of Applicant

By my signature below, I authorize the above parties to release and exchange information for the sole purpose of
determining testing accommodations on the Bar Examination and/or determining fitness to practice law in the State of
Georgia. All necessary information may be released, including medical and psychological records, treatment plans,
histories and progress notes, admission and discharge summaries, laboratory results, psychological and psychiatric
reports, court reports and school records, employment records, psychological, neurological and psycho educational test
data. I understand that this authorization will remain in effect for 90 days from the date of signature. I understand that
I may withdraw this consent at anytime upon written notice. Recipients of this information are forbidden to re-disclose
this information to parties not named above.

______________________________________________________ ________________________________
Signature of Applicant Date

______________________________________________________ ________________________________
Witness Date

NOTE TO APPLICANT:
You MUST copy and complete FORM D as many times as necessary to send to each provider.

FORM D