

BOARD OF BAR EXAMINERS
244 WASHINGTON STREET, SW
SUITE 440
ATLANTA, GA 30334
(404) 656-2003

PETITION FOR TESTING ACCOMMODATIONS

FORM A

To be completed by Applicant

(Please type or legibly print.)

APPLICANT NAME:		
ADDRESS:		
DAY TIME PHONE:		
SOCIAL SECURITY NUMBER:		
DATE OF EXAM YOU ARE SEEKING ACCOMMODATIONS:	Month:	Year:

- 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.**

- Provide the date on which you became disabled: _____

- 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.

Name and Title	Address	Phone Number	Dates of Assessment/ Treatment

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

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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**

Name:	
Title:	
Address:	
Phone:	

- Describe your professional qualifications (terminal degree, a 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) 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 two Multistate Performance Tests answered in the three-hour morning session and four essay questions answered in the three-hour afternoon session. The second day is devoted entirely to the Multistate Bar Examination which consists a two-hundred question, timed, multiple choice examination answered in pencil on a scantron grid sheet. One hundred questions are answered in the three-hour morning session and one hundred questions are answered in the three-hour 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

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CERTIFICATE OF ACCOMMODATIONS

FORM C

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

APPLICANT NAME:	SSN #:
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- 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: _____

- 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).

- 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.

- 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) 656-2003

(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.