IDAHO STATE BAR

**FORM 3: Attention Deficit/Hyperactivity Disorder (ADHD) Verification**

**Notice to applicant**: This section of this form is to be completed by you. The remainder of the form is to be completed by the qualified professional who is recommending accommodations on the bar examination for you on the basis of AD/HD. Please read, complete, and sign below before submitting this form to the qualified professional for completion of the remainder of this form.

Applicant's full name: _____

Date(s) of evaluation/treatment: _____

Date of birth: _____ SSN (last 4): xxx-xx-_____

I give permission to the qualified professional completing this form to release the information requested on the form, and I request the release of any additional information regarding my disability or accommodations previously granted that may be requested by the Idaho State Bar (ISB) or consultant(s) of the ISB.

_____ _____
Signature of applicant Date

**Notice to qualified professional:**
The above-named person is requesting accommodations on the Idaho State Bar Examination. All such requests must be supported by a comprehensive written evaluation report from the qualified professional who conducted an individualized assessment of the applicant and is recommending accommodations on the bar examination on the basis of AD/HD. The ISB also requires the qualified professional to complete this form. **If any of the information requested in this form is fully addressed in the comprehensive evaluation report, you may respond by citing the specific page and paragraph where the answer can be found.** Please attach a copy of the comprehensive evaluation report and all records and test results on which you relied in making the diagnosis and recommending accommodations for the Idaho State Bar Examination. We appreciate your assistance.

The ISB may forward this information to one or more qualified professionals for an independent review of the applicant's request.

Print or type your responses to the items below. Return this completed form, the comprehensive evaluation report, and relevant records and test results to the applicant for submission to the ISB.

**I. Evaluator/Treating Professional Information:**

Name of professional completing this form: _____

Address: _____

City: _____State: _____Zip: _____

Telephone: _____ Fax: _____

E-mail: _____

Occupation and specialty: _____

_____

_____

License number/Certification/State: _____

Describe your qualifications and experience to diagnose and/or verify the applicant's condition or impairment and to recommend accommodations.

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**II. Diagnostic information concerning applicant:**

1. Provide the date the applicant was first diagnosed with AD/HD. _____

2. Did you make the initial diagnosis? ☐ Yes ☐ No

If no, provide the name of the professional who made the initial diagnosis and when it was made, if known. Attach copies of any prior evaluation reports, test results, or other records related to the initial diagnosis that you reviewed.

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3. When did you first meet with the applicant? _____

4. Provide the date of your last complete evaluation of the applicant. _____

5. Describe the applicant's current symptoms of AD/HD that cause significant impairment across multiple settings and that have been present for at least six months. Provide copies of any objective evidence of those symptoms, such as job evaluations, rating scales filled out by third parties, academic records, etc.

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6. Describe the applicant's symptoms of AD/HD that were present in childhood or early adolescence (even if not formally diagnosed) that caused significant impairment across multiple settings. Provide copies of any objective evidence of those symptoms, such as report cards, teacher comments, tutoring evaluations, etc.

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**Attach a comprehensive evaluation report.** The provision of reasonable accommodations is based on assessment of the *current* impact of the disability on the specific testing activity. The ISB generally requires documentation from an evaluation conducted within the last three years to establish the current impact of the disability. The diagnostic criteria as s pecified in the *Diagnostic and Statistical Manual of Mental Disorders,* (DSM-5-TR) (or most current version) are used as the basic guidelines for determination of an Attention Deficit/Hyperactivity Disorder (AD/HD) diagnosis. The diagnosis depends on objective evidence of AD/HD symptoms that occur early in the applicant's development and cause the applicant clinically significant impairment within multiple environments. Applicant self-report alone is generally insufficient to establish evidence for the diagnosis. Please provide a comprehensive evaluation report that addresses all five points below.

A. Sufficient numbers of symptoms (delineated in DSM-5-TR) (or most current version) of inattention and/or hyperactivity-impulsivity that have persisted for at least six months to a degree that is "maladaptive" and inconsistent with developmental level. The exact symptoms should be described in detail;
B. Objective evidence that symptoms of inattention and/or hyperactivity-impulsivity that caused impairment were present during childhood;

C. Objective evidence indicating that current impairment from the symptoms is observable in two or more settings. There must be clear evidence of clinically significant impairment within the academic setting. However, there must also be evidence that these problems are not confined to the academic setting;
D. A determination that the symptoms of AD/HD are not a function of some other mental disorder (such as a mood, anxiety, or personality disorder; psychosis; substance abuse; low cognitive ability; etc.); and
E. Indication of the specific AD/HD diagnostic subtype: predominantly inattentive type, hyperactive-impulsive type, combined type, or not otherwise specified.

**III. Formal testing:**
Psychological testing and self-report checklists cannot be used as the sole indicator of AD/HD diagnosis independent of history and interview. However, such findings can augment clinical data. They are particularly necessary to rule out intellectual limitation as an alternative explanation for academic difficulty, to describe type and severity of learning problems, and to assess the severity of cognitive deficits associated with AD/HD (inattention, working memory, etc.).

1. Is there evidence from empirically validated rating scales completed by more than one source that levels of AD/HD symptoms fall in the abnormal range? ☐ Yes ☐ No

   If yes, please provide copies.

2. Is there evidence from empirically validated rating scales completed by more than one source that the applicant has been significantly impaired by AD/HD symptoms? ☐ Yes ☐ No

   If yes, briefly describe the findings.

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3. Was testing performed that rules out cognitive factors as reasonable explanations for complaints of inattention, distractibility, poor test performance, or academic problems?
   ☐ Yes ☐ No

   If yes, briefly describe the findings.

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4. Was testing performed that rules out psychiatric factors (anxiety, depression, etc.) or test anxiety as reasonable explanations for complaints of inattention, distractibility, poor test performance, or academic problems? ☐ Yes ☐ No

   If yes, briefly describe the findings.

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5. Was testing performed to assess the possibility that a lack of motivation or effort affected test results? ☐ Yes ☐ No

   Describe the findings, including the results of symptom validity tests.

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6. Based on your professional judgment, were the applicant's motivation level, interview behavior, and test-taking behavior adequate to yield reliable diagnostic information? ☐ Yes ☐ No

   If no, please explain.

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**IV. AD/HD treatment:**

Is the applicant currently being treated for AD/HD? ☐ Yes ☐ No

If yes, describe the type of treatment, including any medication, and state the extent to which this treatment is effective in controlling the AD/HD symptoms. If it is effective, explain why accommodations are necessary.

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If no, explain why treatment is not being pursued.

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**V. Accommodations Recommended for the Idaho State Bar Examination:**
The Idaho State Bar Examination is a timed computer based examination administered in three separate three-hour sessions over a day and a half as scheduled twice each year. A lunch break is provided on the first day between Sessions 1 and 2.

Applicants are assigned seats, approximately two per eight-foot table, in a room set for 60 to 200 applicants. They are not allowed to bring food, or other items into the testing room unless approved as accommodations. The examination is administered in a quiet environment, and applicants are allowed to use small foam earplugs provided by the ISB. Applicants are allowed to bring in water as long as it's in a transparent water bottle without labels, and applicants may leave the room only to use the restroom within the time allotted for the test session.

Taking into consideration this description of the examination and the functional limitations currently experienced by the applicant, what test accommodation (or accommodations, if more than one would be appropriate) do you recommend? Check all that apply.

*Examples of accommodations may include modifications to the testing environment, approved items or equipment, off-the-clock breaks, assistive technology, or other measures supported by the applicant's documented functional limitations.*

- ☐ Reduced Distraction Testing Environment
- ☐ Off-the-clock breaks (e.g., time to stretch, walk, take medications, eat, rest eyes, use bathroom, etc.)
- ☐ Extra testing time. Indicate below how much extra testing time is requested
  **Please note if requesting additional time, the testing schedule may change from 1.5 days to 3 days.*

| Test Portion | Standard | Extra Time Requested (in minutes or as %) |
|---|---|---|
| Session 1 – Day 1 AM | 3 hours | |
| Session 2 – Day 1 PM | 3 hours | |
| Session 3 – Day 2 AM | 3 hours | |

☐ Other request(s). Describe in detail, including how the requested accommodation addresses the applicant's functional limitations in the testing environment described above.

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Explain your recommendation(s). If applicable, explain why extra testing time is necessary and describe how you arrived at the specific amount of extra time recommended. If either the amount of time or your rationale is different for different portions of the examination, please explain:

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**VI. PROFESSIONAL'S SIGNATURE:**
**I have attached a copy of the comprehensive evaluation report and all records, test results, or reports upon which I relied in making the diagnosis and completing this form.**

I certify that the information on this form is true and correct based upon the information in my records.

_____ _____
Signature of person completing this form Date signed

_____ _____
Title Daytime telephone number