FORM 4: Psychological Disability 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 a psychological disability. 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 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 a psychological disability. 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 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.

_____

_____

_____

_____

II. Diagnosis and current functional limitations:

1. What is the applicant's current DSM diagnosis (DSM-5-TR or current edition)? If the diagnosis is not definitive, please list any differential diagnoses under consideration.

Primary Diagnosis:

_____

_____

Other Diagnoses (if applicable):

_____

_____

Diagnostic Code(s) (if applicable):

_____

_____

2. Describe the applicant's history of presenting symptoms of a psychological disability. Include a description of symptom frequency, intensity, and duration to establish severity of symptomology.

_____

_____

_____

_____

3. Describe the applicant's current functional limitations caused by the psychological disability in different settings and specifically address the impact of the disability on the applicant's ability to take the bar examination under standard conditions. Note: psychoeducational, neuropsychological, or behavioral assessments often are necessary to demonstrate the applicant's current functional limitations in cognition.

_____

_____

_____

4. Based upon your professional judgment, was the applicant's presentation during the evaluation consistent with the symptoms and limitations described in your report and sufficient to support reliable diagnostic conclusions?

□ Yes □ No

If no, please explain.

_____

_____

5. Describe the applicant's compliance with and response to treatment and medication, if prescribed. Explain the effectiveness of any treatment and/or medication in reducing or ameliorating the applicant's functional limitations and the anticipated impact on the applicant in the setting of the bar examination.

_____

_____

_____

Attach a comprehensive evaluation report. An applicant's psychological disability must have been identified by a comprehensive diagnostic/clinical evaluation that is well documented in the form of a comprehensive report. The report should include the following:

A. Psychiatric/psychological history;
B. Relevant developmental, educational, and familial history;
C. Relevant medical and medication history;
D. Results of full mental status examination;
E. Description of current functional limitations in different settings;
F. Results of any tests or instruments used to supplement the clinical interview and support the presence of functional limitations, including any psychoeducational or neuropsychological testing, rating scales, or personality tests;
G. Diagnostic formulation, including discussion of differential or "rule out" diagnoses; and
H. Prognosis.

III. Accommodations Recommended for the Idaho State Bar Examination:
The Idaho State Bar Examination is a timed computer based examination administered in 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:

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 arrangement(s). Describe in detail.

_____

_____

_____

_____

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:

_____

_____

_____

_____

_____

IV. 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