FORM 5: Visual 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 learning 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.

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 visual 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, reports, test results, or other documentation 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. Provide the applicant's diagnosis.

_____

_____

Include the specific diagnosis and, if applicable, the date of diagnosis and any diagnostic code.

_____

_____

_____

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 evaluations, reports, test results, or records that you reviewed.

_____

_____

3. When did you first meet with the applicant?

_____

4. How long have you treated or evaluated the applicant?

_____

5. Date of last treatment, consultation, or evaluation.

_____

6. Describe the nature, severity, and expected duration of the applicant's visual disability.

_____

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7. Describe the applicant’s current functional limitations.

Describe any limitations affecting reading, computer use, visual processing, visual endurance, visual tracking, visual acuity, field of vision, contrast sensitivity, etc. Address the impact of the visual disability on major life activities and specifically explain how the disability affects the applicant’s ability to take the bar examination under standard testing conditions.

_____

_____

_____

_____

_____

8. Is the condition:

□ Permanent

□ Temporary
□ Episodic
□ Progressive
□ Other: _____
Please explain.

_____

_____

_____

III. Treatment Information:

1. Describe the applicant's current treatment plan, including corrective lenses, magnification devices, assistive technology, therapies, medications, or other interventions

_____

_____

_____

2. Is the applicant following the prescribed course of treatment?

□ Yes □ No

If no, please explain.

_____

_____

_____

3. Describe the effectiveness of the applicant’s treatment in reducing or managing symptoms and functional limitations.

_____

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_____

4. If treatment effectively reduces symptoms or limitations, explain why accommodations remain necessary for the applicant to take the bar examination under standard testing conditions.

_____

_____

IV. Required Supporting Documentation:

Attach a comprehensive evaluation report and all records, reports, or test results upon which you relied on making your diagnosis and recommendations.

The ISB generally requires documentation from an evaluation conducted within the last five years to establish the current impact of a visual disability, unless the nature of the condition warrants more recent documentation.

The evaluation report should include, where applicable:

A. Relevant medical history;
B. Date of onset and progression of the condition;
C. Current diagnosis;
D. Current treatment plan;
E. Relevant treatment history;
F. Visual acuity measurements, when applicable;
G. Visual field measurements, when applicable;
H. Objective findings supporting the diagnosis;
I. Relevant clinical examination findings;
J. Description of current functional limitations;
K. Prognosis; and
L. Rationale for each recommended accommodation.

The focus of the documentation should be the applicant's current functional limitations and how those limitations affect the applicant's ability to take the bar examination under standard testing conditions.

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 water as long as it is 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.

☐ Braille
☐ 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 that if additional testing time is approved, 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 additional testing time is necessary and describe how you arrived at the specific amount of time recommended. If either the amount of time or your rationale differs for various portions of the examination, please explain.

_____

_____

_____

_____

_____

VI. Professional's Signature:

I have attached a copy of the comprehensive evaluation report and all records, test results, reports, or other documentation 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