# State of Rhode Island Judiciary

## Supreme Court – Clerk's Office

Licht Judicial Complex
250 Benefit Street
Providence, RI 02903

## Attention Deficit/Hyperactivity Disorder Verification

**Notice to Applicant**: **You are to complete this section of the form**. The remainder of the form is to be completed by the qualified professional who is recommending accommodations on the Rhode Island Bar Examination for you based on an attention deficit/hyperactivity disorder (AD/HD). Please read, complete, and sign below before submitting this form to the qualified professional for completion of the remainder of this form. You can withhold your consent if you wish, but if consent is refused, the Board of Bar Examiners (BBE) may have to make decisions without the benefit of verified information from your treating physician(s). Please make your choice by signing either Option 1 or Option 2.

Applicant's full name: _____

Applicant's address: _____

Applicant's date of birth: _____

Date(s) of evaluation or treatment: _____

**Option 1**: 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 BBE or consultant(s) of the BBE.

_____ _____
Signature of the Applicant Date

**Option 2**: I refuse to allow consent to contact my treating physician(s) to verify my medical condition relating to my request for special testing accommodations.

_____ _____
Signature of the Applicant Date

**Notice to Qualified Professional**

The above-named person is requesting accommodations on the Rhode Island 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 based on AD/HD. The BBE also requires a 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 Rhode Island Bar Examination. We appreciate your assistance. The BBE may forward this information to one (1) 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 BBE.**

**I. Evaluator or Treating Professional Information**

Name of professional completing this form: _____

Address: _____

Telephone: _____ Facsimile: _____

Email: _____

Occupation and specialty: _____

_____

_____

License number, certification, and 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 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~~ the diagnosis was made, if known. Attach copies of any prior evaluation reports, test results, or other records related to the initial diagnosis that you reviewed.

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 (6) months. Provide copies of any objective evidence of those symptoms, such as job evaluations, rating scales filled out by third parties, academic records, etc.

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.

**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 BBE generally requires documentation from an evaluation conducted within the last three (3) years to establish the current impact of the disability. The diagnostic criteria as specified in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR or most current version) are used as the basic guidelines for determination of an 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. The Applicant self-report alone is generally insufficient to establish evidence for the diagnosis. **Attach to this form a copy of the comprehensive evaluation report that addresses all five (5) points below**.

1. A sufficient number of symptoms (delineated in DSM-IV-TR) of inattention and/or hyperactivity-impulsivity that have persisted for at least six (6) months to a degree that is "maladaptive" and inconsistent with developmental level. The exact symptoms should be described in detail.

2. Objective evidence that symptoms of inattention and/or hyperactivity-impulsivity that caused impairment were present during childhood.

3. Objective evidence indicating that current impairment from the symptoms is observable in two (2) 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.

4. 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.).

5. 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. The findings 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 (1) 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 (1) source that the Applicant has been significantly impaired by AD/HD symptoms? ☐ Yes ☐ No

   If yes, briefly describe the findings.

   _____

   _____

   _____

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.

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.

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.

**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 the treatment is effective, explain why accommodations are necessary.

If No, explain why treatment is not being pursued.

**V. Accommodations Recommended for the Rhode Island Bar Examination (check all that apply)**

The Rhode Island Bar Examination is a timed written examination administered on the last Tuesday and Wednesday in February and July each year. There is a one (1) hour lunch break each day.

The first day consists of two (2) Multistate Performance Test (MPT) questions in the morning session and six (6) essay questions (Multistate Essay Examination (MEE)) in the afternoon session. The MEE and MPT are designed to assess, among other things, the Applicant's ability to communicate the Applicant's analysis effectively in writing. The Applicant may use a personal laptop computers to type answers or they may handwrite answers.

The second day consists of 200 multiple-choice questions Multistate Bar Examination (MBE), with 100 questions administered in the morning session and 100 questions in the afternoon session. The Applicant records answers by darkening circles on an answer sheet that is scanned by a computer to grade the examination.

The Applicant is assigned a seat, two (2) per six-foot table, in a room set for 100 to 400 applicants. The Applicant is not allowed to bring food, beverages, or other items into the testing room unless approved as accommodations. The examination is administered in a quiet environment, and the Applicant is allowed to use small foam earplugs. The Applicant 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 (1) would be appropriate) do you recommend?**

Test question formats:

- ☐ Braille
- ☐ Audio compact disc (CD)
- ☐ Microsoft Word document on data CD for use with screen-reading software (for MEE and MPT sessions)
- ☐ Large print - 18-point font
- ☐ Large print - 24-point font

Assistance:

- ☐ Reader
- ☐ Typist or transcriber for MEE or MPT
- ☐ Scribe for MBE

Explain your recommendation(s). _____

☐ Extra testing time. Indicate below how much extra testing time is recommended:

| Test Portion | Standard Time | Extra Time Recommended |
|---|---|---|
| MPT/Performance | 3 hours a.m. | ☐ 10% ☐ 25%<br>☐ 33% ☐ 50%<br>☐ Other (specify) _____ |
| MEE/Essay | 3 hours p.m. | ☐ 10% ☐ 25%<br>☐ 33% ☐ 50%<br>☐ Other (specify) _____ |
| MBE/Multiple-choice | 3 hours a.m.<br><br>3 hours p.m. | ☐ 10% ☐ 25%<br>☐ 33% ☐ 50%<br>☐ Other (specify) _____ |

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. If relevant, address why extra breaks or longer breaks are insufficient to accommodate the Applicant's functional limitations.

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_____

☐ Extra breaks. Describe the duration and frequency of the recommended breaks. Explain why extra breaks are necessary and describe how you arrived at the length or frequency of breaks recommended. If you also recommending extra testing time, explain why both extra testing time and extra breaks are necessary.

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☐ Other arrangements (e.g., elevated table, limited testing time per day, lamp, medication, etc.). Describe the recommended arrangements and explain why each is necessary.

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**VI. Evaluator or Treating 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 contained in this form is true and correct based upon the information in my records.

_____

Signature of person completing this form Date

_____ _____

Title Daytime telephone number