



State of Rhode Island Judiciary

Supreme Court – Clerk’s Office

Licht Judicial Complex
250 Benefit Street
Providence, RI 02903

Physical Disability 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 a physical disability. 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 evaluation report from the qualified professional who conducted an individualized assessment of the Applicant and is recommending

accommodations on the bar examination based on a physical disability. 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 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 Resulting Functional Limitations

1. What is the specific diagnosis (including diagnosis code) for which the Applicant requests test accommodations?

2. Describe the nature of the physical disability. Include a history of presenting symptoms, date of onset, and description of the duration and severity of the disability.

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

4. When was the Applicant's physical disability first diagnosed? _____

Did you make the initial diagnosis? Yes No

If No, provide the name of the professional who made the initial diagnosis and when 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.

5. Provide the date of your last complete evaluation of the Applicant. _____

6. Is this a permanent condition or impairment? Yes No

If No, when is condition or impairment likely to abate?

7. Does the severity of the condition or impairment fluctuate? Yes No

If Yes, describe the settings and/or circumstances affecting severity that are relevant to taking the bar examination. _____

8. Describe the Applicant’s current functional limitations and explain how the limitations restrict the condition, manner, or duration under which the Applicant can take the bar examination.

9. Briefly describe any treatment, including any prescribed medications, and the effectiveness of treatment in reducing or ameliorating the Applicant’s functional limitations.

III. 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.	<input type="checkbox"/> 10% <input type="checkbox"/> 25% <input type="checkbox"/> 33% <input type="checkbox"/> 50% <input type="checkbox"/> Other (specify) _____
MEE/Essay	3 hours p.m.	<input type="checkbox"/> 10% <input type="checkbox"/> 25% <input type="checkbox"/> 33% <input type="checkbox"/> 50% <input type="checkbox"/> Other (specify) _____
MBE/Multiple-choice	3 hours a.m. 3 hours p.m.	<input type="checkbox"/> 10% <input type="checkbox"/> 25% <input type="checkbox"/> 33% <input type="checkbox"/> 50% <input type="checkbox"/> 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.

- 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.

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

IV. 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