This form is required for applicants who:
(1) Did not previously receive a disability accommodation in law school, college, secondary or primary school, on a bar examination in another jurisdiction, or on other standardized exams or high-stakes testing (e.g., LSAT, SAT, GRE), or
(2) Are requesting a new or greater accommodation (more testing time, longer breaks, etc.) than was provided in previous accommodations

DOC 4 - Initial or Modified ADA Accommodation Request Form

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NOTICE TO APPLICANT: This form is to be completed by each qualified professional who has been involved in the evaluation or treatment of your disability or disabilities in the past 3 years. Please complete and sign this section before submitting the form to your evaluating/treating professional:

Full Name:

Date of birth:

Date(s) of evaluation/treatment:

> I give permission to my evaluating or treating professional referenced below to release the information requested on this form, and I request the release of any additional information regarding my disability or accommodations previously granted as may be requested by the Oregon Board of Bar Examiners or the consultant(s) of the Board.

Signature:

Date:

NOTICE TO EVALUATING/TREATING PROFESSIONAL:

The above-named applicant requests accommodation for a disability[1] when taking the Oregon Bar Examination. In order to assess that request, the Board of Bar Examiners requires current (generally within the last 3 years) documentation of the condition or impairment, and the need for accommodation, based on careful consideration of the applicant by a qualified professional.

You have been named as a qualified professional who has been involved in the evaluation or treatment of the applicant. Qualified professionals are licensed or otherwise properly credentialed and possess expertise in the disability for which modifications or accommodations are sought.

After you complete this form, please return it to the applicant for submission to the Board for consideration of the applicant's request for test accommodations.

This information may be forwarded by the Board of Bar Examiners to one or more other qualified specialists for the purpose of independently evaluating the applicant's request.

Please legibly print or type your responses to the items below.

I. EVALUATING/TREATING PROFESSIONAL INFORMATION:

Name of professional completing this form:

Address:

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[1] Under the Americans with Disabilities Act (ADA), an individual with a disability is a person who has a physical or mental impairment that substantially limits a major life activity (such as seeing, hearing, learning, reading, concentrating, or thinking) or a major bodily function (such as the neurological, endocrine, or digestive system). The determination of whether an individual has a disability generally should not demand extensive analysis and must be made without regard to any positive effects of measures such as medication, medical supplies or equipment, low-vision devices (other than ordinary eyeglasses or contact lenses), prosthetics, hearing aids and cochlear implants, or mobility devices. However, negative effects, such as side effects of medication or burdens associated with following a particular treatment regimen, may be considered when determining whether an individual's impairment substantially limits a major life activity. An impairment that is episodic or in remission is a disability if it would substantially limit a major life activity when active.

A substantial limitation of a major life activity may be based on the extent to which the impairment affects the condition, manner, or duration in which the individual performs the major life activity. To be "substantially limited" in a major life activity does not require that the person be unable to perform the activity. In determining whether an individual is substantially limited in a major life activity, it may be useful to consider, when compared to most people in the general population, the conditions under which the individual performs the activity or the manner in which the activity is performed. It may also be useful to consider the length of time an individual can perform a major life activity or the length of time it takes an individual to perform a major life activity, as compared to most people in the general population.

Telephone:

Fax:

E-mail:

Profession:

License/Certification number/State:

Specialty:

Describe your qualifications and experience to diagnose and/or verify the applicant's disability and to recommend accommodations:

II. DISABILITY VERIFICATION:

To be entitled to accommodation based on a disability, the applicant must provide documentation, at the applicant's expense, that (1) the applicant has a disability and (2) the disability results in functional limitations that require accommodation in order for the applicant to take the examination on an equal basis with other test takers.

Please describe the applicant's disabling medical/psychological condition and how it substantially limits a major life activity:

Please describe the bases for your opinion, including objective evidence used to diagnose the disability (e.g., test results; previous medical records; objective collateral information, including observations by educators or family members; results of psycho-educational or other professional evaluations) which you considered in addition to the applicant's self-report:

Please describe the effect of the disability on the applicant's ability to take the examination under regular testing conditions:

Please indicate below what accommodation(s) you are recommending on behalf of the applicant. For each recommended accommodation, please describe the **rationale** for the recommendation (i.e., *how it best ensures that, when the examination is administered to the applicant, the examination results accurately reflect the applicant's aptitude or achievement level, rather than reflecting the applicant's impairment*):

- ☐ Formats:
  - ☐ Braille version of the examination
  - ☐ Audio version of the examination
  - ☐ Large print, 18-point font
  - ☐ Large print, 24-point font

  Rationale:

- ☐ Assistance:
  - ☐ Reader
  - ☐ Typist/Transcriber
  - ☐ Sign language interpreter

  Rationale:

☐ Extra testing time:

Test Portion	Standard Time	Extra Time Requested	
MPT/Performance (2 MPTs in session)	3 hours	☐ 10%	☐ 25%
		☐ 20%	☐ 50%
		☐ Other (specify):	
Essays (6 essays in each session)	3 hours	☐ 10%	☐ 25%
		☐ 20%	☐ 50%
		☐ Other (specify):	
MBE/Multiple Choice	3 hours AM 3 hours PM	☐ 10%	☐ 25%
		☐ 20%	☐ 50%
		☐ Other (specify):	

Rationale:

☐ Extra breaks. Specify how long and how often breaks are requested:

Rationale:

☐ Other (elevated table, lamp, medication, limited testing time per day, private/semi-private room, etc.). Specify:

Rationale:

I certify that all the information on this form is true and correct.

Qualified professional's signature Date signed

Title Daytime telephone number