

This should only be completed and submitted when accommodation sought relates to a visual disability

DOC 7 - VISUAL DISABILITY VERIFICATION FORM

NOTICE TO APPLICANT: This form is to be completed by each licensed professional who has been involved in diagnosis or treatment of your visual disability or disabilities or who has been involved in making recommendations for test accommodations on the bar examination as a result of your visual disability or disabilities. Please read and sign the following before submitting this form to your evaluator/treating professional(s) for completion:

Full Name: _____

Date(s) of treatment: _____

Date of birth: _____

I give permission to my evaluator 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 of applicant

Date

NOTICE TO EVALUATOR/TREATING PROFESSIONAL:

The above named person is requesting accommodations on the Oregon Bar Examination. You have seen him/her for evaluation and/or treatment. The Board of Bar Examiners needs information and documentation in order to assess that request.

The Board of Bar Examiners (Board) requires a licensed physician or other licensed professional in the field related to the applicant's disability to complete this form. The Board requires current documentation of the condition or impairment (generally within the last three years). 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 a qualified specialist(s) for the purpose of evaluating the applicant's request.

Legibly print or type your responses to the items below.

I. EVALUATOR/TREATING PROFESSIONAL INFORMATION

Name of professional completing this form: _____

Address: _____

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.

Relevant records relating to the applicant, including copies of tests, assessment results, and chart note, must be attached.

II. DISABILITY

1. Briefly describe the applicant's visual and medical history.

2. What is the applicant's current diagnosis.

3. When was this condition or impairment first diagnosed?

4. Please describe treatment, if any, of this condition or impairment (include dates).

5. Is this a permanent condition or impairment?

☐ yes ☐ no

If no, when is this condition or impairment likely to abate?

6. Please state the applicant's best corrected visual acuities for distance and near vision.

7. Please describe the applicant's eye health (both external and internal evaluations).

8. Briefly describe how the applicant's condition or impairment affects his or her reading ability.

9. Is the applicant substantially limited in one or more major life activities? ☐ yes ☐ no

If yes, identify all such major life activities and describe the substantial limitation(s) and functional impact on the applicant's ability to take the examination under standard conditions.

III. DIAGNOSIS-SPECIFIC FINDINGS (ADDRESS ALL RELEVANT AREAS)

1. Visual Field: threshold field, not confrontation (provide measurements and copies of reports)

2. Binocular Evaluation: eye deviation (provide measurements), diplopia, suppression, depth, etc. Specify the distance or near point.

3. Accommodative Skills: at near point, with and without lenses (provide measurements)

4. Oculomotor Skills: saccades, pursuits, tracking

IV. ACCOMMODATIONS RECOMMENDED FOR THE OREGON BAR EXAMINATION

The Oregon Bar Examination is administered in two 3 hour sessions on Tuesday; and two 3 hour sessions on Wednesday, as scheduled twice each year.

Lunch breaks are one hour and 30 minutes each day.

Based on the applicant's condition or impairment and your diagnosis, what test accommodations, if any, would you recommend? (Check all that apply.)

Formats:

- ☐ Braille version of examination
- ☐ Audio version of examination
- ☐ Large print – 18-point font
- ☐ Large print / 24-point font

Assistance:

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

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

Test Portion	Standard Time	Extra Time Requested
MPT/Performance (2 MPT's in session)	3 hours	<input type="radio"/> 10% <input type="radio"/> 25% <input type="radio"/> 20% <input type="radio"/> 50% <input type="radio"/> Other (specify) _____
Essays (6 essays in session)	3 hours	<input type="radio"/> 10% <input type="radio"/> 25% <input type="radio"/> 20% <input type="radio"/> 50% <input type="radio"/> Other (specify) _____
MBE/Multiple Choice	3 hours AM 3 hours PM	<input type="radio"/> 10% <input type="radio"/> 25% <input type="radio"/> 20% <input type="radio"/> 50% <input type="radio"/> Other (specify) _____

☐

Extra breaks. How long and how often are additional breaks requested?

If you are recommending extra time on the essay, performance, and/or multiple choice portion(s) of the examinations, please explain why extra breaks are also necessary.

Please provide your rationale for recommending extra time and for the amount of additional time recommended on the essay portion(s) of the examination.

Please provide your rationale for recommending extra time and for the amount of additional time recommended on the performance portion(s) of the examination.

Please provide your rationale for recommending extra time and for the amount of additional time recommended on the multiple-choice portion(s) of the examination.

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Other arrangements requested (e.g., elevated table, lamp, medication, seat near restroom, limited testing time per day, private/semi-private room, etc.).

V. PROFESSIONAL'S SIGNATURE

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

Signature of person completing this form

Date signed

Title

Daytime telephone number