

DISABILITY FORM 6: PHYSICAL DISABILITY VERIFICATION - OLC

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 test accommodations on the Ohio Law Component (OLC) for you on the basis of 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.

Applicant's full name:

Date(s) of evaluation/treatment:

Applicant's date of birth:

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 Ohio Board of Bar Examiners (Board) or consultant(s) of the Board.

Signature of applicant

Date

NOTICE TO QUALIFIED PROFESSIONAL:

The above-named person is requesting accommodations on the OLC. 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 Ohio Law Component on the basis of a physical disability. The Board 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 evaluation report and all records and test results on which you relied in making the diagnosis and recommending accommodations for the OLC. We appreciate your assistance.

The provision of reasonable accommodations is based on assessment of the *current* impact of disability on the specific testing activity. The Board generally requires documentation from an evaluation conducted within the past year because of the changing manifestations of many physical disabilities. Older evaluation reports may suffice if supplemented by an update of the diagnosis, current level of functioning, and a rationale for each recommended accommodation or an explanation of why the report continues to be relevant in its entirety.

The Board 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. 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, or directly to testingaccommodations@sc.ohio.gov.**

I. EVALUATOR/TREATING PROFESSIONAL INFORMATION

Name of professional completing this form:

Address:

Telephone:

E-mail:

Occupation and specialty:

License number/State:

Name of Licensing Board (e.g., nursing, psychology, medical, counseling/social work/marriage, and family therapy, etc.)

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 it 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/impairment?

☐ Yes ☐ No

If no, when is it likely to abate?

7. Does the severity of the condition/impairment fluctuate?

☐ Yes ☐ No

If yes, describe the settings and/or circumstances affecting severity that are relevant to taking the OLC.

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 OLC.

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

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III. ACCOMMODATIONS RECOMMENDED FOR THE OLC (CHECK ALL THAT APPLY)

The OLC is a timed, closed-book, multiple-choice examination administered in one two-hour session. The OLC is administered at least four times a year, consisting of 50 multiple choice questions. Applicants record their answers using a computer program. The examination is administered using remote proctoring technology. Applicants are not allowed to bring food, beverages, or any other items into the testing room unless approved as accommodations.

Applicants who need assistance with answering multiple-choice questions will need a scribe to assist them.

Taking into consideration this description of the examination and the functional limitations currently experienced by the applicant, what test accommodation(s) do you recommend? (Check all that apply.)

Assistance:

- ☐ Screen Reader Software, No Scribe
- ☐ Screen Reader Software, With Scribe

Explain your recommendation(s).

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

	Standard Time	Extra Time Recommended - Select One
OLC	2 hours	☐ 25% ☐ 33% ☐ 50% ☐ 100% ☐ No extra time

Explain why extra testing time is necessary and describe how you arrived at the specific amount of extra time recommended.

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Do you have any other recommendations regarding accommodations for this applicant? If so, please explain the recommendation and the rationale you used in making that recommendation.

[illegible]

IV. 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 on this form is true and correct based upon the information in my records.

Signature of Professional

Date signed

Title

Daytime telephone number