

DISABILITY FORM 4: PSYCHOLOGICAL 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 accommodations on the Ohio Law Component (OLC) for you on the basis of a psychological 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 bar examination on the basis of a psychological 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 comprehensive 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 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. **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 CURRENT FUNCTIONAL LIMITATIONS

1. What is the applicant's DSM-V (or most current version) diagnosis/diagnoses? If diagnosis is not definitive, please list differential diagnoses.

2. Describe the applicant's history of presenting symptoms of a psychological disability. Include a description of symptom frequency, intensity, and duration to establish severity of symptomology.

3. Describe the applicant's current functional limitations caused by the psychological disability in different settings and specifically address the impact of the disability on the applicant's ability to take the Ohio Law Component under standard conditions. Note: psychoeducational, neuropsychological, or behavioral assessments often are necessary to demonstrate the applicant's current functional limitations in cognition.

4. Describe the applicant's compliance with and response to treatment and medication, if prescribed. Explain the effectiveness of any treatment and/or medication in reducing or ameliorating the applicant's functional limitations and the anticipated impact on the applicant in the setting of the Ohio Law Component.

ATTACH A COMPREHENSIVE EVALUATION REPORT. An applicant's psychological disability must have been identified by a comprehensive diagnostic/clinical evaluation that is well documented in the form of a comprehensive report. The report should include the following:

- psychiatric/psychological history
- relevant developmental, educational, and familial history
- relevant medical and medication history
- results of full mental status examination
- description of current functional limitations in different settings
- results of any tests or instruments used to supplement the clinical interview and support the presence of functional limitations, including any psychoeducational or neuropsychological testing, rating scales, or personality tests
- diagnostic formulation, including discussion of differential or "rule out" diagnoses
- prognosis

III. ACCOMMODATIONS RECOMMENDED FOR THE OHIO LAW COMPONENT (CHECK ALL THAT APPLY)

The Ohio Law Component ("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	
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.

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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