Form B

REASONABLE TESTING ACCOMMODATIONS
DISABILITY DOCUMENTATION

A physician or other qualified professional in the field related to the applicant's disability must complete this form. The Kansas Board of Law Examiners requires current documentation. Current is defined as no more than three years old. This form must be submitted with the completed application for accommodations.

Physician OR Qualified Professional Information

(Please Type or Print Legibly)

Name: _____

Occupation, Title & Specialty: _____

License or Certification Number: _____

Address: _____

Telephone Number: _____

Applicant's Name: _____

1. **Please describe your credential(s) which qualify you to diagnose and/or verify the applicant's disability and to recommend an accommodation.**

2. **What is the specific diagnosis of the condition or impairment that requires the applicant to request testing accommodations?**

3. **Briefly describe the nature of the condition or impairment and describe how it affects the applicant in a test situation**.

4. **Current treatment consists of**:

5. **Length of treatment with applicant:** _____
   Date of last treatment/consultation: _____

6. **Is this a permanent condition?** _____

7. **If the condition/disability is not of a permanent nature, please explain**.

8. **In what way does the condition/disability prevent the applicant from taking the examination under standard testing conditions? (A testing room with 150 - 200 applicants; two three-hour sessions of essay questions on day one and two three-hour sessions of standardized multiple choice questions on day two**.)

9. **Given the applicant's condition/disability and your diagnosis, what testing accommodations do you recommend? Check all that apply.**

   Large Print 18 pt._____ 24 pt._____ ; Braille_____ ; Audio Tape_____ ; Typewriter_____ ; Computer & Printer_____ ; Separate Room_____ ; Additional Time_____ ; Other (be specific):

10. **If additional time is recommended, please indicate for which type of examination. Essay:_____ ; Multiple Choice:_____**

11. **How will the accommodations requested compensate for the disability**?

Provide copies of all tests used for diagnosis, reports, chart notes, or other written documentation supporting or explaining this diagnosis of disability and/or recommendation for accommodations.

I certify that all the information on this form and all additional documentation provided by my office is true and correct to the best of my knowledge and belief.

_____

Signature of Physician or Qualified Professional **Name (Print)** **Date**

I understand this information may be reviewed by a physician or qualified professional retained by the Kansas Board of Law Examiners to assist in determining reasonable testing accommodations.