APPLICANT REQUEST FOR TEST ACCOMMODATIONS

Full Name: _____

Date of Birth: _____ Student Number: _____

I. YOUR DISABILITY STATUS

1. Check the disability or disabilities for which you are requesting accommodations.

☐ Learning disability	☐ Visual impairment
☐ AD/HD	☐ Hearing impairment
☐ Physical disability	☐ Psychological disability
☐ Other (describe) _____	

2. Age when first diagnosed: _____

3. Are you currently being treated? ☐ Yes ☐ No

   If yes, provide the name, qualifications, and telephone number of your treating professional(s).

   _____

   _____

   _____

   _____

4. List any treatment and/or medication currently prescribed for the disability or disabilities identified above, or list "none."

   _____

   _____

   _____

   _____

5. Is the treatment or medication effective in controlling symptoms?

   ☐ Yes ☐ No ☐ N/A

   If no, describe remaining symptoms and any side effects.

   _____

   _____

   _____

   _____

6. Did you receive special accommodations in college (undergraduate or graduate studies)?

   ☐ Yes ☐ Not Requested ☐ Denied ☐ N/A

   If yes, please explain the accommodations received. If you were denied accommodations, please explain on what grounds your request was denied.

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   _____

   _____

   _____

7. Did you receive accommodations for any of the following standardized tests?

   LSAT ☐ Yes ☐ Not Requested ☐ Denied ☐ N/A

   MCAT ☐ Yes ☐ Not Requested ☐ Denied ☐ N/A

   GRE ☐ Yes ☐ Not Requested ☐ Denied ☐ N/A

   GMAT ☐ Yes ☐ Not Requested ☐ Denied ☐ N/A

   SAT ☐ Yes ☐ Not Requested ☐ Denied ☐ N/A

   ACT ☐ Yes ☐ Not Requested ☐ Denied ☐ N/A

8. Did you receive accommodations or disabled-student services in high school, including but not limited to, accommodations or services provided as a result of an Individualized Education Plan (IPE) or a 504 Plan? ☐ Yes ☐ Not Requested ☐ Denied ☐ N/A

   If yes, please provide a brief summary as to the diagnosis upon which your IEP or 504 Plan was granted.

   _____

   _____

III. ACCOMMODATIONS REQUESTED

The medical provider in charge of treatment and/or care must complete the Accommodations Requested portion of the Provider section.

IV. SUPPORTING DOCUMENTATION

Requests for accommodations must be supported by the following requested documentation from third parties. Documentation created by you or your family will not be considered. All documentation must be submitted at the same time as your request for special accommodations.

1- Medical documentation: Supporting medical documentation from a qualified professional who conducted an individualized assessment and who provided the diagnosis which forms the basis for the request for special accommodations MUST be provided. If you are requesting special accommodations based on more than one diagnosis, then you MUST provide the stated medical documentation for each diagnosis. Each medical provider MUST complete the following form. If the provider does not use BSL's form, and information is missed or not provided, special accommodations may not be granted until this issue is remedied.

2- If you answered in the affirmative to Questions 6, 7 or 8, you MUST provide verifying documentation of your accommodation history. This may be achieved by requesting a certification of accommodation history from the institution, and/or providing a copy of the letter(s) received notifying you of your special accommodation requested being granted, and/or providing copies of your IEP or 504 Plan(s).

V. CERTIFICATION THAT INFORMATION SUPPLIED IS TRUE AND COMPLETE

_____Initial The information I have provided in support of my request for test accommodations is true and complete.

_____Initial I understand that if Birmingham School of Law determines that I, or a third party on my behalf, submitted as part of this request any information or documentation that is false, inaccurate, or intentionally misleading, Birmingham School of Law reserves the right deny my application, submit my transgression to the Honor Court for investigation, or both.

_____Initial I understand that both my request for test accommodations and all supporting documentation may be submitted for evaluation to one or more qualified professionals retained by Birmingham School of Law, and I authorize such disclosure.

_____Initial I understand that all necessary documentation and information must be provided to BSL within thirty (30) days of the beginning of the final exam period of my first term of law school, or within thirty (30) days of diagnosis, whichever is most recent, and that my request for test accommodations will not be considered and will be denied if the deadline is missed. Any request received less than thirty

(30) days before the final exam period starts for a term will not be granted until the following term.

_____Initial I understand my accommodation only applies to in-class graded midterm and final examinations and that as a general rule, special testing accommodations do not extend to written assignments to be completed outside of class.

_____Initial I understand "private" testing is administered to resemble conditions at the Alabama Bar exam and is administered in a classroom with other students spaced out accordingly unless the accommodation granted allows for a reader and/or typist- those such accommodations are administered in a room without other students.

_____Initial I understand if I am granted leave for breaks, any break taken comes out of my overall time, and I may not bring or access any materials or electronics.

_____ _____

Applicant signature Date signed

If you are unable to sign this form, please have someone sign and date in your presence.

_____ _____

Signature of individual signing on behalf of Applicant Date signed

Relationship to Applicant: _____

Reason(s) why Applicant cannot sign this form:

_____

_____

_____

_____

SPECIAL TESTING ACCOMMODATIONS VERIFICATION FORM

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 at Birmingham School of Law for you. 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: _____

Applicant's SSN: _____-_____-_____ 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 Birmingham School of Law.

_____ Signature of Applicant Date: _____/_____/_____

NOTICE TO QUALIFIED PROFESSIONAL: The above-named person is requesting special testing accommodations at Birmingham School of Law. All such requests must be supported by a comprehensive written report from the qualified professional who conducted an individualized assessment of the Applicant and is recommending accommodations for the person while he/she is enrolled at Birmingham School of Law.

There are multiple sections in this form, some which may not apply to the Applicant. Please complete all applicable sections in this report and return it directly to Birmingham School of Law by mail: Birmingham School of Law, Attn: Special Accommodations 231 22nd Street South, Birmingham, AL 35233 or by email to ttaack@bsol.com, subject line: Special Accommodations. If you have any questions, please reach out to our administrative office at (205) 322-6122.

I. EVALUATOR/TREATING PROFESSIONAL INFORMATION

Name of professional completing this form: _____

Name of Practice/Employment: _____

Address: _____

Telephone: _____ E-mail: _____

Occupation and specialty: _____

Describe your qualifications and experience to diagnose and/or verify the Applicant's condition or impairment and to recommend accommodations.

_____

_____

_____

_____

II. LEARNING DISABILITY

1. Provide the date the Applicant was first diagnosed: _____/_____/_____

2. Provide the full medical diagnosis: _____

3. Did you make the initial diagnosis? Yes or No? _____ If no, provide the name of the professional who made the initial diagnosis and when it was made, if known.

_____

_____

4. Provide the date of your last complete evaluation of the Applicant. _____/_____/_____

5. Provide a concise description of your diagnosis. Please include the specific DSM-IV-TR (or most current version) diagnosis:

_____

_____

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6. Describe the Applicant's current level of functioning and the impact of any functional limitations on the Applicant's major life activities.

_____

_____

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_____

7. Was the Applicant's motivation level, interview behavior, and/or test-taking behavior adequate to yield reliable diagnostic information/test results? Yes or No? _____

Describe how this determination was made, including whether any symptom validity tests were administered. If such tests were not administered, please state why they were not.

_____

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_____

III. FORMAL TESTING (AD/HD)

1. Is there evidence from empirically validated rating scales completed by more than one source that levels of AD/HD symptoms fall in the abnormal range? Yes or No? _____

2. Is there evidence from empirically validated rating scales completed by more than one source that the Applicant has been significantly impaired by AD/HD symptoms? Yes or No? _____ If yes, briefly describe:

_____

_____

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3. Was testing performed that rules out cognitive factors as reasonable explanations for complaints of inattentions, distractibility, poor test performance or academic problems? Yes or No? _____ If yes, briefly describe:

_____

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4. Was testing performed that ruled out psychiatric factors (anxiety, depression, etc.) or test anxiety as reasonable explanations for complaints of inattention, distractibility, poor test performance or academic problems? Yes or No? _____ If yes, briefly describe:

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5. Was testing performed to assess the possibility that a lack of motivation or effort affected test results? Yes or No? _____ If yes, briefly describe, including the results of symptom validity tests:

_____

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6. Is the Applicant currently being treated for AD/HD? Yes or No? _____ If yes, describe the treatment, including any medication, and state the extent to which this treatment is effective in controlling the AD/HD symptoms. If it is effective, explain why accommodations are necessary with effective treatment. If no, explain why treatment is not being pursued.

_____

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_____

IV. PSYCHOLOGICAL DISABILITY

1. What is the Applicant's DSM-IV-TR (or most current version) diagnosis? Please complete all fives axes. If diagnosis is not definitive, please list differential diagnoses.

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V _____

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 a law school exam under standard conditions. Note: psychoeducational, neuropsychological or behavioral assessments are often necessary to demonstrate the Applicant's current functional limitations in cognition.

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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 a law school examination.

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V. VISUAL DISABILITY

1. What is the Applicant's current diagnosis? Include a statement as to whether the condition is stable or progressive.

2. Please state the Applicant's best corrected visual acuities for distance and near vision

3. Please describe the Applicant's eye health, both external and internal.

4. If applicable, please describe the visual field: threshold field, not confrontation

5. If applicable, please describe the binocular evaluation: eye deviation (provide measurements), diplopia, suppression, depth perception, convergence, etc. Specify whether the difficulty lies with distance, near point or both.

6. If applicable, accommodative skills: at near point, with and without lenses (provide measurements)

7. If applicable, oculomotor skills: saccades, pursuits, tracking

8. Describe the functional impact, if any, of the Applicant's visual condition on the Applicant's reading ability.

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_____

VI. PHYSICAL DISABILITY

1. What is the specific diagnosis (including diagnosis code) for which the Applicant requests test accommodations?

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_____

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_____

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.

_____

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_____

_____

3. When was the Applicant's physical disability first diagnosed? _____/_____/_____

4. Did you make the initial diagnosis? Yes or No? _____ If no, provide the name of the professional who made the first diagnosis and when it was made, if known

_____

_____

5. Is this a permanent condition/impairment? Yes or No? _____ If no, when is it likely to abate?

_____

_____

6. Does the severity of the condition/impairment fluctuate? Yes or No? _____ If yes, describe the settings and/or conditions affecting severity that are relevant to taking standard law school examinations.

_____

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7. Describe the Applicant's current functional limitations and explain how the limitations restrict the condition, manner, or duration under which the Applicant can take law school examinations.

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8. 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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VII. RECOMMENDED ACCOMMODATIONS

1. Provider only, please sign by any of the following test question formats you recommend the Applicant use:

_____ Braille

_____ Audio CD

_____ Large print/18-point font

_____ Large print/ 24-point font

2. Provider only, please sign by any of the following additional assistance formats you recommend the Applicant use:

_____Reader (student must provide)

_____Typist for essays (student must provide)

_____Scribe for multiple-choice (student must provide)

3. Do you recommend granting the Applicant additional testing time? ☐ No ☐ Yes

Provider only, please sign by any of the following additional testing time you recommend

_____25% Additional Testing Time (15 additional minutes per hour)

_____50% Additional Testing Time (30 additional minutes per hour)

_____75% Additional Testing Time (45 additional minutes per hour)

Please explain your rationale for the additional testing time recommended.

_____

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4. If you recommend granting the Applicant additional in-class breaks, please describe the duration and frequency of the requested breaks and explain your rationale for the extra breaks. Please note if a student is allowed to leave for breaks, it will only granted without the student having access to materials/electronics. Additional time is not granted for breaks and come out of student's overall accommodations time. Describe the duration and frequency of the requested breaks

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5. Taking into consideration your diagnosis, treatment and any functional limitations, what additional test accommodation(s), if any, would you recommend and why?

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VIII. PROFESSIONAL'S SIGNATURE

I hereby certify that the information on this form is true and correct based upon the information in my records.

Printed name of the person completing this form:_____

Signature of the person completing this form: _____

Title: _____

Name of Practice/Employment: _____

Date signed: _____/_____/_____

Daytime telephone number: _____

Email address: _____