

MASSACHUSETTS BOARD OF BAR EXAMINERS
Request for Special Arrangement
for a Health-Related Condition

Applicant Name (please print): _____

Date of Birth: _____ Tel. #: _____

E-mail: _____

Nature of Request: _____

Medication(s): _____

Equipment: _____

Other: _____

Contact Information in case of emergency:

Medical Professional's Name/Tel. #: _____

Emergency Contact Person's Name/Tel. #: _____

Applicant's Signature: _____

Send this form, at least 3 weeks prior to the first day of
the bar exam, to:

Board of Bar Examiners
John Adams Courthouse, Suite 5-140
One Pemberton Square, Boston, MA 02108

OR

Attach completed form and email to:
info@bbe.state.ma.us

For Board of Bar Examiners Use Only:

Boston **Springfield** **Section/Room** _____ **Seat #** _____

Approved by: _____ **Date:** _____ **Applicant Notified:** _____ **Date:** _____

The information provided by this form is intended solely for use in the event of a medical emergency or incident that may occur during the bar examination. Only the Board, the Board's staff, proctors, and emergency medical personnel will have access to this information.