MASSACHUSETTS BOARD OF BAR EXAMINERS
FORM 3: VISUAL DISABILITY VERIFICATION

NOTICE TO APPLICANT: This section of this form is to be completed by you or someone on your behalf in your presence. The remainder of the form is to be completed by the qualified professional who is recommending accommodations on the Massachusetts Bar Examination for you on the basis of a visual 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 Massachusetts Board of Bar Examiners or consultant(s) of the Massachusetts Board of Bar Examiners.

Signature of applicant: _____ Date: _____

(If signed on behalf of the applicant) Relationship to Applicant _____

Signature: _____ Date: _____

NOTICE TO QUALIFIED PROFESSIONAL:

The above-named person is requesting accommodations on the Massachusetts Bar Examination. All such requests must be supported by a comprehensive diagnostic evaluation by the qualified professional who conducted an individualized assessment of the applicant and is recommending accommodations on the Massachusetts Bar Examination on the basis of a visual disability. The Board of Bar Examiners requires the qualified professional to complete all questions on this form that pertain to the applicant's visual impairment. Reference specific tests or other objective data and clinical observations, and **attach copies of test results**, if relevant.

The Board of Bar Examiners may forward this information to one or more qualified professionals for an independent review of the applicant's request.

Type or legibly print your responses to the items below that pertain to the applicant's visual impairment. **Return this completed form and copies of relevant test results to the applicant for submission to the Board.**

I. EVALUATOR/TREATING PROFESSIONAL INFORMATION

Name of professional completing this form: _____

Address: _____

Telephone: _____ Fax: _____

Email: _____

Occupation and specialty: _____

_____

License number/Certification/State: _____

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

Provide a concise description of the applicant's condition requiring accommodations. Include a statement as to the age of onset, course of illness, and description of symptom frequency, intensity, duration, and whether the condition is stable or progressive.

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

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

Describe any treatment, including visual aids and prescribed medications.

Describe the applicant's current functional limitations in major life activities (as defined by the ADA*), and specifically address the impact of the disability on the applicant's ability to take the bar examination under standard conditions (see **Part IV** of this form for a description of the standard exam).

*DISABILITY - a physical or mental impairment that **substantially limits one or more major life activities**.
MAJOR LIFE ACTIVITIES - include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. Major life activity also includes the operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions. (Per the ADAAA of 2008.)

III. DIAGNOSIS-SPECIFIC FINDINGS – ONLY ADDRESS RELEVANT AREAS

In the space below, please address only items 1-4 that are applicable to the applicant.

1.) Please describe the applicant's **eye health** (both external and internal evaluations).
2.) **Visual Field**: threshold field, not confrontation (provide measurements and copies of reports).
3.) **Binocular Evaluation**: eye deviation (provide measurements), diplopia, suppression, depth perception, convergence, etc. Specify whether difficulty with distance, near point, or both.
4.) **Accommodative Skills**: at near point, with and without lenses (provide measurements).

IV. ACCOMMODATIONS RECOMMENDED FOR THE MASSACHUSETTS BAR EXAM

The Massachusetts Bar Examination is a timed, in-person examination administered over two days in four, three-hour sessions, from approximately 9:30a.m. to 12:30p.m. and from approximately 2:00p.m. to 5:00p.m. There are scheduled breaks between each testing session on both testing days. The bar exam is administered twice each year, in February and July.

The first day consists of two performance tests (MPT) in the morning and six essay (MEE) questions in the afternoon. The performance and essay questions are designed to assess, among other things, the applicant's ability to communicate their analysis effectively in writing. Questions are provided in hard-copy booklets, and applicants may handwrite or use their personal laptop computers to record their answers.

The second day consists of 200 multiple-choice questions (MBE), with 100 questions administered in the morning session and 100 questions in the afternoon session. Questions are provided in hard-copy booklets, and applicants record their answers by completing a scantron form.

Applicants are seated at a space pre-assigned by the Board of Bar Examiners. They are allowed to have water at their testing space, and are provided with foam earplugs. Other items requested require approval as accommodations. The examination is administered in-person. Applicants are required to refrain from speaking. They may leave their seat only to use the restroom and must notify the proctor that they are doing so. Applicants are monitored by trained proctors.

Taking into consideration this description of the examination and the functional limitations currently experienced by the applicant, what test accommodations do you recommend?

☐ **Extra Testing Time**

Indicate below how much extra testing time is recommended.
Note: For applicants awarded 50% additional time or more, the UBE will be administered over a four-day period.

Test Portion	Standard Time	Extra Time Requested (% extra time per 3 hr. session)
MPT/Performance Test	3 hours	☐ _____% Extra time ☐ Off-The-Clock Breaks
MEE/Essay	3 hours	☐ _____% Extra time ☐ Off-The-Clock Breaks
MBE/Multiple-Choice	Two 3-Hour Sessions	☐ _____% Extra time ☐ Off-The-Clock Breaks

(Continued on next page)

☐ **Alternate Test Format:**

- ☐ Braille
- ☐ Audio USB
- ☐ Electronic test questions (compatible with screen reading software)
- ☐ Use of dictation (speech-to-text) software for MEE and MPT responses
- ☐ MBE Circling (responses transferred to scantron by BBE staff)
- ☐ Large print/18-point font
- ☐ Large print/24-point font
- ☐ Other _____

☐ **Other accommodations**. Describe the recommended arrangements (e.g., lumbar support, lamp, standing desk, etc.) and explain why each is necessary.

Explain each recommendation below.

A) If recommending extra testing time, explain why extra testing time is necessary and describe how you arrived at the **specific amount** of extra time recommended.

B) Address why extra breaks or longer breaks are insufficient to accommodate the applicant's functional limitations

C) If either the amount of time or your rationale is different for different portions of the examination, please explain.

V. 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. (REQUIRED)**

I certify under penalty of perjury that the foregoing is true and correct.

Signature	Date Signed
Title	Daytime Telephone Number