



ARKANSAS BOARD OF LAW EXAMINERS

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Guidelines for Documentation of Disabilities

The purpose of this document is to assist applicants and qualified professionals in completing accommodation requests to the Arkansas Board of Law Examiners for an upcoming administration of the Arkansas Bar Examination.

A qualified applicant with a disability who is otherwise eligible to take the Arkansas Bar Examination, but who cannot demonstrate under standard testing conditions the knowledge and skills necessary for admission, may request reasonable testing accommodations. The Arkansas Board of Law Examiners (Board) provides reasonable and appropriate accommodations for qualified applicants with documented disabilities who demonstrate a need for accommodation and who meet the definition of disability under the Americans with Disabilities Act of 1990, as amended (ADA), along with applicable regulations and case law.

All applications for accommodations and supporting documentation will be submitted to one or more experts in the relevant disability area for impartial review. The Board may require an applicant to provide additional information or documentation and may also require the applicant to undergo an evaluation by a professional designated by the Board.

To help navigate this document, the guidelines and documentation for the specific disabilities found in this document can be found on these pages:

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DOCUMENTATION OF PHYSICAL AND PSYCHIATRIC DISABILITIES

The Americans with Disabilities Act (ADA) as amended defines a person with a disability as someone with a physical or mental impairment that substantially limits one or more major life activities. To support an application for testing accommodations based on a disability, applicants must provide recent medical documentation of their disability that is comprehensive. The following guidelines are provided to assist you and your clinician in documenting the need for accommodations. Documentation that fails to fully comply with the Board's guidelines may result in the rejection of the application for the testing accommodations as incomplete.

PHYSICAL DISABILITIES

If you are requesting test accommodations based on a physical disability, you must provide a recent comprehensive written report prepared by a qualified professional who has conducted an individualized assessment which demonstrates compliance with the following requirements:

1. **Format.** The report should be on professional letterhead, typed, dated, signed and otherwise legible. A doctor's note or script is generally insufficient.
2. **Qualifications of the qualified professional.** The report must establish the professional credentials of the qualified professional that qualify him/her to make the particular diagnosis, including information about license or certification, specialization in the diagnosis and training and direct experience in the area of the diagnosis. If multiple diagnoses are given, the qualified professional must demonstrate he or she is qualified to make all diagnoses.
3. **Current Nature of the Disability.** The granting of reasonable testing accommodations is based on an assessment of the applicant's current ability to take the bar examination under standard conditions. The report must indicate the date the patient was last seen by the Qualified Professional. Since the manifestations of a disability may vary over time and in different settings, the following guidelines apply:
 - A. **PERMANENT DISABILITIES:** If you have a disability that has been present since birth, or is expected to be permanent, or is not expected to improve over time, provide a copy of your most recent medical evaluation. If further information is needed to comply with these guidelines, attach prior evaluations as necessary.
 - B. **RECENT OR TEMPORARY DISABILITIES:** If you have a disability that has not been present since birth, or is expected to be temporary, or is expected to improve with time, your medical documentation should be no more than one year old measured from the date of the evaluation to the date of your current application or re-application for testing accommodations.
4. **Diagnosis.** The Qualified Professional must state a professionally recognized diagnosis.
5. **Diagnostic Procedure(s).** The report must describe the specific diagnostic criteria and/or diagnostic tests used, including the date(s) of the evaluation(s), the tests performed, and a detailed interpretation of the test results. The report should include relevant educational, developmental, and medical history. Diagnostic methods used should be appropriate to the disability and current professional practices within the field. Informal or non-standardized evaluations should be described in enough detail that other professionals could understand their role and significance in the diagnostic process.

For vision disabilities, the report should include a description of general eye health; a binocular evaluation; visual acuity with and without corrective lenses for distance and near point acuities; focusing skills at distance and near point (with and without lenses); coulometer skills; and visual fields.

If the Qualified Professional reports a *cognitive problem* caused by the disability or a medication taken for the disability, then the claim may need to be supported by a brief but psychological test battery. The report should state the specific functional limitation caused by the disability or medication and provide objective test data demonstrating the limitation. The test data must show a deficiency that effects the candidate's ability to take the bar examination, usually the candidate's ability to read and/or write. Test results must be reported using age norms where available. Also, where available, test scores should be compared to the appropriate normative group. (e.g., depressed normative group, non-depressed normative group).

6. **Functional Limitations.** The report should list any major life activities that are affected by the individual's current condition and explain how the impairment substantially limits those major life activities as compared to most people. The report should describe the individual's functional limitations due to the diagnosed disability and how the limitations will substantially limit the individual's ability to take the bar examination under regular testing conditions. The report must relate the functional limitation to one or more aspect of the standard bar examination. An individual's ability to take the bar examination under regular testing conditions. The report must relate the functional limitation to one or more aspect of the standard bar examination.
7. **Amelioration of the Functional Limitations.** The report should contain a description of current treatments, assistive devices, medications, etc. that ameliorate the impact of the disability. If a particular treatment or device that could ameliorate the functional limitations has been tried and rejected, explain what it is and why it has been rejected.
8. **Recommendation.** The report must include a specific data-based recommendation for testing accommodations using objective methods to determine the need for the recommended accommodation. The recommendation should include a detailed explanation of why the accommodation is needed and how it will reduce the impact of the identified functional limitations. If extra examination time is recommended, the report must explain how extra examination time will reduce the impact of the functional limitation.
9. **History of Accommodations.** If accommodations have not been provided in the past, the report should include a detailed explanation of why no accommodations were needed in the past and why accommodations are needed now.

PSYCHAITRIC DISABILITIES

If you are requesting testing accommodations based on a psychiatric disability, you must provide a complete and recent assessment by a qualified mental health professional in the form of a comprehensive written report which demonstrates compliance with the following requirements:

1. **Format.** The report should be on professional letterhead, typed dated, signed, and otherwise legible. A doctor's note or script is generally insufficient.
2. **Qualifications of the qualified professional.** The report must establish the professional credentials of the Qualified Professional that qualify him/her to make the particular diagnosis,

including information about license or certification specialization in the area of the diagnosis, and training and direct experience in the area of the diagnosis. If multiple diagnoses are given, the Qualified Professional must demonstrate he or she is qualified to make all diagnoses.

3. **Current Nature of the Disability.** The granting of reasonable testing accommodations is based on an assessment of the applicants current ability to take the bar examination under standard conditions. The report must indicate the date the patient was last seen by the Qualified Professional. Since the manifestations of psychiatric disabilities may vary over time and in different settings, your medical documentation should be no more than one year old measured from the date of the evaluation to the date of your current application or re-application for testing accommodations.
4. **Diagnosis.** The Qualified Professional must state a DSM diagnosis. Please note that mild test anxiety, which is the tendency to become very nervous and perform poorly in testing situations, does not generally qualify as disability under the ADA and is not generally accommodated on the bar examination. If you suffer from test anxiety, you are advised to obtain treatment well in advance of the exam.
5. **Diagnostic Procedure(s).** The clinician who conducts the assessment must administer:
 - A. A clinical interview addressing all DSM criteria;
 - B. As many self-report scales as are necessary to corroborate the severity of any diagnosed psychiatric disorders;
 - C. A brief account of the applicant's psychiatric, medical, and educational history;
 - D. A multi-axial diagnostic summary including a Global Assessment of Functioning rating; and
 - E. Effort testing (malingering).

Reliance on self-report data alone is insufficient to document a psychiatric disability. Clinicians are also encouraged to use other sources of evidence in their diagnostic analysis. If a standardized interview is not used, then the clinician must provide a detailed synopsis of exactly which symptoms were endorsed, which conditions were ruled out, and all other information on how the diagnosis was arrived upon.

The medical documentation submitted with the application for testing accommodations must include a complete and current assessment. It is not enough for a clinician to state that an applicant has a long-standing condition or that the applicant is currently in treatment. There must be a recent evaluation and diagnostic report regardless of the candidate's prior history or current treatment, especially if there was no diagnostic interview administered in the medical record.

If the clinician reports a cognitive problem caused by the disability or a medication taken from the disability, then the claim may need to be supported by a brief but well conceived psychological test battery. The report should state the specific functional limitation caused by the disability or medication and provide objective test data demonstrating the limitation. The test data must show a deficiency that effects the candidates ability to take the bar examination, usually the candidate's ability to read and/or write. Test results must be reported using age norms where available. Also

where available, test scores should be compared to the appropriate normative group (e.g., depressed normative group, non-depressed normative group).

6. **Functional Limitations.** The report should list any major life activities that are affected by the individual's current condition and explain how the impairment substantially limits those major life activities as compared to most people. The report should describe the individual's functional limitations due to the diagnosed disability and how the limitations will substantially limit the individual's ability to take the bar examination under regular testing conditions. The report must relate the functional limitation to one or more aspect of the standard bar examination. A description of the Indiana bar examination and what is expected of applicants is set forth below.
7. **Amelioration of the Functional Limitations.** The report should contain a description of current treatments, assistive devices, medications, etc. that ameliorate the impact of the disability. If a particular treatment or device that could ameliorate the functional limitations has been tried and rejected explain what it is and why it has been rejected.
8. **Recommendation.** The report must include a specific data-based recommendation for testing accommodations using objective methods to determine the need for the recommended accommodation. The recommendation should include a detailed explanation of why the accommodation is needed and how it will reduce the impact of the identified functional limitations. If extra examination time is the recommendation, the report must explain how the extra examination time will reduce the impact of the functional limitation.
9. **History of Accommodations.** If accommodations have not been provided in the past, the report should include a detailed explanation of why no accommodations were needed in the past and why accommodations are needed now.

DOCUMENTATION OF LEARNING DISABILITIES AND OTHER COGNITIVE DISORDERS

The Americans with Disabilities Act (ADA) as amended defines a person with a disability as someone with a physical or mental impairment that substantially limits one or more major life activities. To support an application for testing accommodations based on a disability, you must provide recent medical documentation of your disability that is comprehensive. The following guidelines are provided to assist you and your clinician in documenting the need for accommodations. Documentation that fails to fully comply with the Board's guidelines may result in the rejection of the application for testing accommodations as incomplete. Candidates must provide a comprehensive psycho-educational or neuropsychological assessment which contains the following information:

1. **Qualifications of the Qualified Professional.** The report must establish the professional credentials of the Qualified Professional that qualify him/her to make the particular diagnosis, including information about license or certification, specialization in the area of the diagnosis and training and direct experience in the area of the diagnosis. If multiple diagnoses are given, the Qualified Professional must demonstrate he or she is qualified to make all diagnoses.

2. **The documentation must be current.** The granting of reasonable testing accommodations is based on assessment of the current impact of the applicant's disability on the testing activity. Since the manifestations of the disability may vary over time and in different settings, the following guidelines apply:
- A. Generally, your medical documentation should be no more than four years old measured from the date of the evaluation to the date of your current application or re application for testing accommodations.
 - B. If an evaluation is outdated or inadequate in scope or content, it should be updated by a qualified professional to address the current level of functioning and the continued need for testing accommodations.
3. **Documentation must be comprehensive.** Objective evidence of substantial limitation in cognition or learning must be provided. Reports must be on professional letterhead, typed, dated, signed, and otherwise legible and contain the following information:
- A. Diagnostic Interview and History Taking:
The assessment report should include a summary of a comprehensive diagnostic interview that includes relevant background information to support the diagnosis. Since learning disabilities are commonly manifested during childhood, though not always formally diagnosed, relevant historical information regarding the applicant's academic history and learning processes in elementary, secondary, and post-secondary education should be documented. In addition to the applicant's self-report, the report of assessment should include:
 - A description of the presenting problem(s) including DSM symptoms;
 - Developmental, academic, medical, psychosocial and employment histories;
 - Relevant family history, including primary language of the home and the applicant's current level of fluency in English (i.e., English as a Second Language)
 - Relevant academic history including results of prior standardized testing, reports of classroom performance and behaviors including transcripts, study habits and attitudes and notable trends in academic performance;
 - A discussion of dual diagnosis, alternative or co-existing mood, behavioral, neurological, personality and/or psychiatric disorders along with any history of relevant medication and current medication that may impact the individual learning; and
 - Exploration of possible alternatives which may mimic a learning disability when, in fact, one is not present (e.g., motivational problems).
 - B. Assessment:
The neuropsychological or psycho-educational evaluation must provide clear and specific evidence that a learning or cognitive disability exists. Assessment must consist of a comprehensive battery of tests that does not rely on any one test or subtest. Tests must be appropriately normed for the age of the patient and must be administered in the designated

standardized manner. Any resulting diagnosis must be based on the aggregate of the test results, history, and level of current functioning. Objective evidence of a substantial limitation to learning or other major life activity must be provided. Minimally, the domains to be address must include the following:

1. **Aptitude** – A complete intellectual assessment with all subtests and age-based standard scores reported (percentiles alone are unacceptable). Acceptable measures include, but are not limited, to the following: Wechsler Adult Intelligence Scale-Fourth Edition (WAIS – IV); Woodcock-Johnson – III: Tests of Cognitive Ability; Kaufman Adolescent and Adult Intelligence Test; and Stanford-Binet Intelligence Scale (5th Ed). Earlier versions of the WAIS are not acceptable. Also, the tests must have norms appropriate for the age of the applicant. The Slosson Intelligence Test – Revised and the Kaufman Brief Intelligence are primarily screening devices, which are not comprehensive enough to provide the kinds of information necessary to make accommodation decisions.
2. **Achievement** – A comprehensive achievement battery with all subtests and age-based standard scores reported (percentiles alone are unacceptable). The battery must include current levels of academic functioning in relevant areas such as reading (decoding and comprehension), writing and written language. Acceptable instruments include but are not limited to the following: Woodcock-Johnson III: Tests of Achievement; The Scholastic Abilities Test for Adults (SATA); Stanford Test of Academic Skills; Woodcock Reading Mastery Tests-Revised and the Wechsler Individual Achievement Test –III.

Specific achievement tests such as, the Test of Written Language (TOWL), the Wide Range Achievement Test (WRAT), and the Nelson-Denny Reading Test (NDRT) may be useful instruments when administered under standardized conditions and when interpreted within the context of other diagnostic information. However, they are not comprehensive measures of achievement and not acceptable if used as the sole measure of achievement. If these measures are used, you must identify the norms that are being used.

3. **Information Processing** – Specific areas of information processing (e.g., short- and long-term memory; sequential memory; auditory and visual perception/processing; processing speed; executive functioning; motor ability) must be assessed. Acceptable instruments include, but are not limited to, the following; the Detroit Tests of Learning Aptitude – Adult (DTLA-A), Woodcock-Johnson III; Tests of Cognitive Ability, Wechsler Memory Scale – III (WMS-III), as well as other relevant instruments that may be used to address these areas.
4. **Effort Testing** – The candidate’s effort during the testing must be measured to address the issue of malingering.

5. Other Assessment Measures – Other assessment measures such as non-standard measures and informal assessment procedures or observations may be helpful in determining performance across a variety of domains. Other formal assessment measures may be integrated with the above instruments to help determine a learning disability and differentiate it from co-existing neurological and/or psychiatric disorders (i.e., establish a differential diagnosis).

C. Test Scores:

Age-based Standard scores, as well as the form of test used, must provide for all normed measures. (Percentiles alone are not acceptable.) It is helpful to list all test data in a score summary sheet appended to the report. Grade equivalents are not useful unless age-based standard scores and percentiles are also included. The data should logically reflect a substantial limitation to learning for which the patient is requesting accommodation. The particular profile of the patient's strengths and weaknesses must be shown to relate to functional limitations that necessitate accommodations. The tests used must be current, reliable, valid, and standardized for use with an adult population. The test findings should document both the nature and severity of the disability. Informal inventories, surveys, and direct observation by a qualified professional may be used in tandem with formal tests in order to further develop a diagnosis and recommend accommodations.

D. DSM Diagnosis:

A specific DSM diagnosis must be included in the report, and alternative explanations must be ruled out. Individual "learning styles," "learning differences," "academic problems," English as a Second Language, and "test difficulty or anxiety," do not by themselves constitute a learning disability for which accommodations will be granted. Where indicated in the DSM, the diagnosis must include identification of the significant discrepancy (Criterion A) and the significant impairment (Criterion B) and a full discussion of each. The diagnosis must be supported by the test data, history, anecdotal and clinical observations that may include comments about the applicant's level of motivation, study skills, and other non-cognitive factors. These findings must demonstrate that the patient's functional limitations are the result of the diagnosed disability. It is important to rule out alternative explanations for problems in learning such as emotional, attention or motivational problems that may be interfering with learning but do not constitute a disability. The clinician is encouraged to use direct language in the diagnosis and documentation of a disability, avoiding the use of terms such as "suggests" or "is indicative of."

E. Records of academic history:

Since learning disabilities commonly have a childhood onset, relevant records detailing difficulties in elementary, secondary and postsecondary education should be reviewed by the examiner and discussed in the report. Copies of any academic records (transcripts, report cards, teacher comments, standardized test scores) and previous neuropsychological records that are reviewed by the Qualified Professional and cited in his/her report should be annexed to the report. Such records will serve to substantiate self reported academic difficulties.

F. Clinical Summary:

A well-written diagnostic summary based on a comprehensive evaluative process is a necessary component of the report. Assessment instruments and the data they provide do not diagnose; rather, they provide important data that must be integrated by the Qualified Professional with background information, historical information, and clinical observations of the applicant during the testing situation, and current functioning. It is essential then that the qualified professionals integrate all information gathered in a well developed clinical summary. The clinical summary must include:

- a. Demonstration that the Qualified Professional has ruled out alternative explanations for academic problems as a result of poor education, poor motivation and/or study skills, emotional problems, attention problems and cultural or language differences;
- b. Indication of how patterns in cognitive ability, achievement and information processing are used to determine the presence of a disability;
- c. An indication of the substantial limitation to current learning or other major life activity presented by the disability and the degree to which it impacts the individual in the context of the bar examination;
- d. Indication as to why specific accommodations are needed and how the effects of the specific disability are mediated by the recommended accommodations; and
- e. Indication of any corrective measures (i.e., medications, assistive devices) that alleviate the substantial limitation and the extent thereof.

4. **Recommendations for Accommodations and Rationale:** The report must include specific databased recommendations for accommodations as well as a detailed explanation as to why each accommodation is necessary. The Qualified Professional should describe the impact the diagnosed disability has on a specific major life activity as well as the degree of significance of this impact on the individual. The Qualified Professional should support recommendations with specific test results or clinical observations.

The summary should also include any record of prior accommodation or auxiliary aids, including any information about specific conditions under which the accommodations were used (e.g., standardized testing, final exams, and licensing or certification examinations). It is important to recognize that accommodation needs can change over time and are not always identified through the initial diagnostic process. If no prior accommodations have been provided, the qualified professional should include a detailed explanation as to why no accommodations were needed in the past and why accommodations are needed now.

DOCUMENTATION OF ATTENTION DEFICIT/ HYPERACTIVITY DISORDER (AD/HD)

The Americans with Disabilities Act (ADA) as amended defines a person with a disability as someone with a physical or mental impairment that substantially limits one or more major life activities. To support an application for testing accommodations based on a disability, you must provide recent medical documentation of your disability that is comprehensive. The following guidelines are provided to assist you and your clinician in documenting the need for accommodations. Documentation that fails to fully comply with the Board's guidelines may result in the rejection of the application for testing accommodations as incomplete. Candidates must provide a comprehensive psycho-educational or neuropsychological assessment which contains the following information:

- 1. Qualifications of the Qualified Professional.** The report must establish the professional credentials of the Qualified Professional that qualify him/her to make the particular diagnosis, including information about license or certification, specialization in the area of the diagnosis and training and direct experience in the area of the diagnosis. If multiple diagnoses are given, the Qualified Professional must demonstrate he or she is qualified to make all diagnoses.
- 2. The documentation must be current (Recent Documentation).** The granting of reasonable testing accommodations is based on assessment of the current impact of the applicant's disability on the testing activity. Since the manifestations of the disability may vary over time and in different settings, the following guidelines apply:
 - A. Generally, your medical documentation should be no more than four years old measured from the date of the evaluation to the date of your current application or re-application for testing accommodations.
 - B. If an evaluation is outdated or inadequate in scope or content, it should be updated by a qualified professional to address the current level of functioning and the continued need for testing accommodations.
- 3. Documentation to substantiate the disability must be comprehensive.** Objective evidence of a substantial limitation in a major life activity must be provided. Since the symptoms of ADHD are first exhibited in childhood (although it may not have been formally diagnosed) and are manifested in more than one setting, objective, relevant, historical information is essential. Therefore, a clinical evaluation should provide information verifying a chronic course of ADHD symptoms from childhood through adolescence to adulthood, such as educational transcripts, report cards, teacher comments, tutoring evaluations, job assessments, past psycho educational testing, etc. At a minimum, the comprehensive written report must be on professional letterhead, typed, dated, signed, and otherwise legible and should contain the following information:
 - A. Diagnostic interview and history taking:
The report must include a summary of a comprehensive diagnostic interview that includes relevant background information to support the diagnosis. Information collected by the qualified professional must consist of more than self-report. Information from third party sources are critical in the diagnosis of adult ADHD. The evaluation must include a

summary of a comprehensive diagnostic interview that should include, but not necessarily be limited to, the following:

1. History of presenting attention symptoms, including evidence on ongoing impulsive/hyperactive or inattentive behavior that has significantly impaired functioning over time;
2. Developmental history;
3. Family history for presence of ADHD and other educational, learning, physical or psychological difficulties deemed relevant by the examiner;
4. Relevant medical and medication history, including the absence of a medical basis for the symptoms being evaluated;
5. Relevant psychosocial history and any relevant interventions;
6. A thorough academic history of elementary, secondary and postsecondary education;
7. Review of prior psycho-educational test reports to determine whether a pattern of strengths or weaknesses is supportive of attention or learning problems; and
8. Relevant employment history.

B. Assessment:

A neuropsychological or psycho-educational assessment may be necessary in order to determine the individual's pattern of strengths or weaknesses and to determine whether there are patterns supportive of attention problems. Test scores or subtest scores alone should not be used as a sole basis for the diagnostic decision. Age-based standard scores must be provided for all normed measures. Selective subtest scores from measures of intellectual ability, memory functions tests, attention or tracking tests, or continuous performance tests do not in and of themselves establish the presence or absence of ADHD. They may, however, be useful as one part of the process in developing clinical hypotheses. Checklists and/or surveys can serve to supplement the diagnostic profile but by themselves are not adequate for the diagnosis of ADHD and do not substitute for clinical observations, evidence from history, an analysis of current functioning, and sound diagnostic judgment. When testing is used, age-based standard scores must be provided for all normed measures. In addition, effort should be tested to address the issue of malingering.

C. Identification of DSM-IV Criteria:

The report must include a review and discussion of the DSM diagnostic criteria and ADHD both currently and retrospectively and specify which symptoms are present and the extent to which the patient currently meets those criteria. The report must also include:

1. Symptoms of hyperactivity-impulsivity or inattention that cause impairment that were present in childhood;
2. Current symptoms that have been present for at least the past six months; and
3. Impairment from the symptoms across several life settings (home, school, work, social, etc.)

D. A Specific Diagnosis:

The report must include a specific diagnosis of ADHD based on the DSM diagnostic criteria. Individuals who report problems with organization, test anxiety, memory and concentration only on a situational basis do not fit the prescribed diagnostic criteria for ADHD. Given that many individuals benefit from prescribed medications and therapies, a positive respond to medication by itself is not supportive of a diagnosis, nor does the use of medication in and of itself either support or negate the need for accommodations.

E. Records of academic history:

Since ADHD, by definition, is a disorder with a childhood onset (although it may not have been formally diagnosed until later) that impairs more than one life setting, relevant, objective, historical information is essential to the diagnosis. Information and documentation verifying a chronic course of ADHD symptoms across various life settings from childhood through adolescence to adulthood (i.e. academic transcripts, report cards, teacher comments, standardized test scores, employment records, etc.) are necessary and should be reviewed by the examiner and attached to the report where available. Such records will serve to substantiate self-reported symptoms and academic difficulties.

F. Clinical Summary:

A well-written diagnostic summary based on a comprehensive evaluative process is a necessary component of the report. Assessment instruments and the data they provide do not diagnose; rather, they provide important data that must be integrated by the Qualified Professional with background information, historical information, and clinical observations of the applicant during the testing situation, and current functioning. It is essential then that the qualified professionals integrate all information gathered in a well-developed clinical summary. The clinical summary must include:

1. discussion of the differential diagnosis, including alternative or co-existing mood, behavioral neurological and/or personality disorders that may confound the diagnosis of ADHD;
2. Exploration of possible alternative diagnoses as well as educational and cultural factors impacting the applicant that may mimic ADHD;
3. Demonstration that the qualified professional has ruled out alternative explanations for inattentiveness, impulsivity, and/or hyperactivity as a result of psychological or medical disorders or non-cognitive factors;

4. An indication of how patterns of inattentiveness, impulsivity and/or hyperactivity across the life span and across settings are used to determine the presence of ADHD;
5. An indication of the substantial limitation to current learning or other major life activity presented by ADHD and the degree to which it impacts the individual in the context of the bar examination;
6. An indication of whether medication has been tried as a method of treatment, what results were obtained and if medication is not an appropriate treatment, why not;
7. An indication of whether or not the applicant was evaluated while on medication, whether or not there is a positive response to the prescribed treatment, and whether or not a positive response to the treatment obviated the need for testing accommodation; and
8. An indication as to why specific accommodations are needed and how the effects of ADHD symptoms, as designated by the DSM are mediated by the accommodations.

4. Recommendations for Accommodations and Rationale: The report must include specific databased recommendations for accommodations as well as a detailed explanation as to why each accommodation is necessary. The Qualified Professional should describe the impact the diagnosed ADHD has on a specific major life activity as well as the degree of significance of this impact on the individual. The Qualified Professional should support recommendations with specific test results or clinical observations. The summary should also include any record of prior accommodation or auxiliary aids, including any information about specific conditions under which the accommodations were used (e.g., standardized testing, final exams, and licensing or certification examinations). It is important to recognize that accommodation needs can change over time and are not always identified through the initial diagnostic process. If no prior accommodations have been provided, the qualified professional should include a detailed explanation as to why no accommodations were needed in the past and why accommodations are now needed.