

NST FORM 5: VISUAL DISABILITY VERIFICATION

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 on the 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: _____ SSN: _____

I give permission to the qualified professional completing this form to release the information requested on the form.

Signature of applicant

Date

NOTICE TO QUALIFIED PROFESSIONAL:

The above-named person is requesting accommodations on the Connecticut 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 bar examination on the basis of a visual disability. The Connecticut Bar Examining Committee (Committee) 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. We appreciate your assistance.

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

Print **legibly** or type 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 Committee.**

I. EVALUATOR/TREATING PROFESSIONAL INFORMATION

Name of professional completing this form: _____

Address: _____

Telephone: _____ E-mail: _____

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

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.

III. DIAGNOSIS-SPECIFIC FINDINGS. ONLY ADDRESS RELEVANT AREAS.

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)

5. Oculomotor Skills: saccades, pursuits, tracking

IV. FUNCTIONAL LIMITATIONS

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

V. ACCOMMODATIONS RECOMMENDED FOR THE CONNECTICUT BAR EXAMINATION (CHECK ALL THAT APPLY)

DESCRIPTION OF THE CONNECTICUT STATE BAR EXAMINATION

The examination is made up of three sections of three hours each, administered over one and a half days. The first day consists of one 3-hour morning session and one 3-hour afternoon session, with a lunch break in between. The second day of the examination consists of one 3-hour morning session.

The examination is administered in electronic format using the applicant's laptop. Each examination session is comprised of forty (40) standalone multiple-choice questions, two (2) Integrated Question Sets, and one (1) Performance Task. An integrated question set includes multiple choice and medium-answer and/or short-answer questions. A performance task is either one extended-response writing assignment, or multiple-choice and short-answer questions followed by a medium-length writing assignment. Applicants may freely navigate between all questions in a session and are free to use their time as they choose in each session.

Applicants are typically seated two to a 6-foot table and are provided with scratch paper. They are permitted to leave their desk to go to the restroom and to utilize a water station. All applicants are permitted to wear ordinary foam ear plugs during the examination and to take any necessary over-the-counter and legally prescribed medications (e.g. pills taken orally and topical creams).

Taking into consideration this description of the examination and the functional limitations currently experienced by the applicant, what test accommodation (or accommodations, if more than one would be appropriate) do you recommend?

Test Format:

- ☐ Braille
- ☐ Screen reader support (e.g., text to speech, JAWS, NVDA, VoiceOver)
- ☐ Speech to text (e.g., Dragon or similar speech recognition tools)

*Font size selection, platform color selection, and browser zoom are available to all applicants and do not require an accommodation.

Explain your recommendation(s). _____

☐ Extra testing time. Indicate below how much extra testing time is recommended:

Test Portion	Standard Time	Extra Time Requested (25%, 50%, or 100%** of the standard time)
Day 1	AM Session – 3 hours	
	PM Session – 3 hours	
Day 2	AM Session - 3 hours	

**The 100% additional testing time schedule necessitates an onsite, proctor-supervised lunch break.

Explain why extra testing time is necessary and describe how you arrived at the specific amount of extra time recommended. If either the amount of time or your rationale is different for different portions of the examination, please explain. If relevant, address why extra breaks or longer breaks are insufficient to accommodate the applicant's functional limitations.

- ☐ Extra breaks. Describe the duration and frequency of the recommended breaks. Explain why extra breaks are necessary and describe how you arrived at the length or frequency of breaks recommended. If you are also recommending extra testing time, explain why both extra testing time and extra breaks are necessary.

- ☐ Other arrangements (e.g., elevated table, permission to bring item(s) such as lumbar cushion or other necessary medical supplies, etc.). Describe the recommended arrangements and explain why each is necessary.

VI. PROFESSIONAL'S SIGNATURE

I have attached a copy of all records, test results, or reports upon which I relied in making the diagnosis and completing this form.

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

Signature of person completing this form

Date signed

Title

Daytime telephone number