

**FORM 20B / DESCRIPTION OF EVALUATION,  
TREATMENT, OR COUNSELING RELATING TO  
CRIMINAL CASES OR TRAFFIC VIOLATIONS  
INVOLVING ALCOHOL OR DRUGS**

Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Relevant date(s) or date range(s): \_\_\_\_\_

Describe the reason(s) why you sought evaluation, treatment, and/or counseling: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Describe the evaluation, treatment, and/or counseling you received: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Identify any treating physician or counselor (if applicable):

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_

Postal/ZIP Code: \_\_\_\_\_ Country: \_\_\_\_\_

Telephone: \_\_\_\_\_ Facsimile: \_\_\_\_\_

Email: \_\_\_\_\_

Identify hospital or institution (if applicable):

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_

Postal/ZIP Code: \_\_\_\_\_ Country: \_\_\_\_\_

Telephone: \_\_\_\_\_ Facsimile: \_\_\_\_\_

*The Board of Bar Examiners of the Delaware Supreme Court is aware of HIPAA requirements.*