FORM 27A / DESCRIPTION OF CONDITION, DISABILITY, OR IMPAIRMENT

Full Name: _____

Date of Birth: _____ Social Security Number: _____

Relevant date(s) or date range(s): _____

Describe the condition or impairment: _____

_____

_____

Describe any treatment, or any program that includes monitoring or support: _____

_____

_____

_____

_____

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.