FORM 8 / DESCRIPTION OF CONDITION OR IMPAIRMENT

Name ____
First *Middle* *Last* *Suffix*

Relevant dates: From Mo/Yr________________To Mo/Yr_______________

Describe the condition or impairment______________________________

Describe any treatment, or any program that includes monitoring or support______________

Name and complete address of attending physician or counselor (if applicable):

*Name of physician or counselor*______________________________

*Physician's or counselor's current address*______________________________

*City*______________________*State*_*Zip*______________ *Country*__________

______________________*Province*______________________

Telephone (___)______________________________

Name and complete address of hospital or institution (if applicable):

*Name of hospital or institution*______________________________

*Hospital's or institution's current address*______________________________

*City*______________________*State*_*Zip*______________ *Country*__________

______________________*Province*______________________

Telephone (___)______________________________

The Board of Law Examiners of the State of North Carolina is aware of HIPAA requirements.