

Form B – PHYSICAL DISABILITY VERIFICATION

- **APPLICANT AUTHORIZATION** (must be signed and notarized before submitting the entire Form B to your licensed healthcare professional for completion).
- **HEALTHCARE PROFESSIONAL FORM** (must be completed by the licensed healthcare professional who is/was most recently involved in the treatment of your disability).

APPLICANT AUTHORIZATION

Applicant's Name: _____

Date of Birth: _____ SSN: XXX-XX-_____

Form B: Physical Disability: (type) _____

I hereby authorize the release of the information requested on this form, and I request that all such additional items supporting my disability be attached to this form and returned to me for submission to the Virginia Board of Bar Examiners.

Signature of Applicant

===== SECTION BELOW MUST BE COMPLETED BY A NOTARY PUBLIC =====

Commonwealth/State/District of _____

County/City of _____

I, a Notary Public of such County/City, certify that on this day personally appeared before me

who thereupon made oath that all statements contained in this application are true and complete.

Given under my hand this _____ day of _____, _____

My commission expires on _____, _____

Notary Public

Registration Number (if applicable) _____

NOTARY SEAL (must be affixed)