To be used with Question 10

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 ______________________________

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Describe any treatment, or any program that includes monitoring or support ____________

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____

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* __________

Telephone (______) ______________ *Province* __________

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* __________

Telephone (______) ______________ *Province* __________

The Supreme Court of Ohio is aware of HIPAA requirements.