Indiana Bar Application

Form B-1

(Use to Supplement Questions 20, 21, 22, 23, 24, 25 & 26; Please Print Clearly or Type; make as many copies as necessary to report each instance on a separate form.)

Name: _____

First Middle Last

Social Security Number: _____

Date Treatment Began: _____ Date Treatment Ended: _____

(Month/Year) *(Month/Year)*

Name and complete address of the attending physician, counselor, health professional, Clergy ("Provider") applicable to this response:

Name of Provider _____

Address _____

City, State, Zip _____

Telephone Number _____

Name and complete address of any hospital, outpatient clinic or institution:

Name of hospital or institution _____

Address _____

City, State, Zip _____

Telephone Number _____

Detailed description of the type of problem, condition, impairment, diagnosis, treatment and/or monitoring program:

(use supplemental sheet(s) if necessary)