NOTICE OF INTENT TO RAISE DISABILITY IN MITIGATION

In accordance with Board Rule 7.6, the undersigned Respondent hereby submits this notice of intent to raise disability in mitigation in the below-captioned disciplinary proceeding(s) and provides the following information and releases in connection with the notice. Respondent understands that full and complete responses must be submitted to the questions posed in this notice and attached forms, and that they shall become a part of the record in the matter(s) in which the notice is filed.

1. Name:

_____

2. Disciplinary Docket number of case(s) in which notice is being filed:

_____

_____

_____

3. The Disability Claim

(a) State the nature of the disability(ies) (physical, mental or addictive) that you intend to raise in mitigation pursuant to Board Rule 7.6:

_____

_____

_____

_____

_____

_____

_____

(b) State the name, address and telephone number of each physician, psychiatrist, psychologist, therapist, counselor, or other medical provider who has treated you or is treating you for the disability(ies) listed in subsection (a), above. Provide the dates of treatment, and file a release in the form attached hereto as Form A.

Name	Address	Telephone No.	Dates of Treatment

(c) State the name, address and telephone number of any hospital, outpatient clinic, treatment facility or other institution where you have received treatment or counseling for the disability(ies) listed in section (a) above, and the dates of treatment/counseling. State the name, address and telephone number of

each attending physician, psychiatrist, psychologist, therapist, counselor or other medical provider not listed in subsection (b) above, and file a release in the form attached hereto as Form A.

Name	Address	Telephone No.	Dates of Treatment

(d) State your present condition.

_____

_____

_____

_____

_____
Respondent

Date:_____

Form A

AUTHORIZATION TO RELEASE MEDICAL RECORDS AND FILES

Upon presentation of the original or a photocopy of this signed authorization, I (Respondent's name)_____, authorize (Name, address of physician, psychiatrist, psychologist, therapist, counselor or other medical provider) _____

_____

_____

and (Name, address of hospital, clinic, treatment facility or other institution):_____

_____

_____

(hereafter, "the Provider(s)") to provide information, including copies of my records and files, concerning advice, care or treatment provided to me, without limitation, relating to illness or disability, and/or use of drugs or alcohol to a representative of the Office of the Disciplinary Counsel, and/or the District of Columbia Board on Professional Responsibility for the following dates of service: from _____ to_____. I understand that any information as may be received will become part of Disciplinary Counsel's file in any disciplinary proceeding

brought against me by Disciplinary Counsel where I raise my disability(ies) in mitigation. I further understand that should Disciplinary Counsel decide to offer any of the information received as evidence in such proceeding, Disciplinary Counsel will so advise me in order to provide me an opportunity to apply for a protective order.

I hereby release, discharge and exonerate the Office of Disciplinary Counsel, its agents and representatives, the Board on Professional Responsibility, its agents and representatives, and the Provider(s), its agents and representatives, so furnishing information, from any and all liability or every nature and kind arising out of the furnishing, inspection and/or use of such documents, records and other information, by the Office of Disciplinary Counsel and/or the Board on Professional Responsibility. I further acknowledge that information disclosed pursuant to this authorization may be redisclosed by the recipient and is no longer protected by HIPAA Privacy Rule, 45 C.F.R. §164.508(c)(2).

I reserve the right to revoke this authorization in accordance with HIPAA Privacy Rule, 45 C.F.R. §164.508(c)(2). Said revocation will be in writing to the Provider(s) and the revocation will not apply to disclosures made in reliance

upon the authorization before it was received by the Provider(s).

This release expires on _____.

_____
Signature of Respondent

Date of Birth_____*

Social Security No._____

SUBSCRIBED and SWORN to before me this_____day of_____,

_____.

_____
Notary Public

Seal or Stamp must be affixed to each original.

* This identifying information may be necessary to obtain the requested information from the provider designated above. Please note that Board Rule 19.8(f)(i) provides that Social Security Numbers and Dates of Birth must be redacted from any document filed with a Hearing Committee or the Board.

DISTRICT OF COLUMBIA COURT OF APPEALS
BOARD ON PROFESSIONAL RESPONSIBILITY

In the Matter of:	:	
	:	
_____	:	Disc. Docket No. _____
	:	
Respondent.	:	

ACKNOWLEDGEMENT OF DISABILITY (OR ADDICTION)

I, _____, hereby acknowledge that during the period of _____, I suffered from a disability
(beginning and ending dates)

(or addiction) by reason of _____.
(identify infirmity or illness, or additional)

In this disciplinary proceeding against me, I am contending that the alleged violations of the Code of Professional Responsibility would not have occurred but for such disability (or addiction), and I am requesting mitigation of sanctions based on such disability (or addiction). I understand, and hereby stipulate, that this acknowledgement may be used by the Board on Professional Responsibility, if appropriate under the provisions and limitations of Board rule 11.12, in seeking from the District of Columbia Court of Appeals an order imposing probationary conditions or suspensions from the practice of law pursuant to Section 13(e) of Rule XI of the Rules Governing the Bar.

_____
Respondent

Date:_____