# Supreme Court of Wisconsin

BOARD OF BAR EXAMINERS
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## MEDICAL INFORMATION FORM

NOTE: This form must be completed for affirmative ("yes") answers to Questions 33, 34 or 35 on the Applicant Questionnaire and Affidavit. This form must be typewritten or computer generated.

Name _____
(first, middle, last)

Dates of treatment: From (mo/yr) _____ To (mo/yr) _____

Medications prescribed (attach additional pages as necessary)

_____

Attending health care professional _____
(name, title)

Street address _____

City _____ State _____ Zip code _____

Telephone _____

Name of hospital or institution _____

Street address _____

City _____ State _____ Zip code _____

Telephone _____

Describe the condition or problem and any treatment or monitoring program (attach additional pages as necessary).

_____