

To be used with Questions 25 and 26
**FORM 8 / DESCRIPTION OF MENTAL HEALTH OR
SUBSTANCE ABUSE CONDITION OR IMPAIRMENT**

Name _____
First Middle Last Suffix

Dates of treatment: From Mo/Yr _____ To Mo/Yr _____

Name and complete address of attending physician or counselor:

Name of physician or counselor _____

Physician's or Counselor's current address _____

City _____ *State* _____ *Zip* _____

Country _____ *Province* _____

Telephone () _____

Name and complete address of hospital or institution:

Name of hospital or institution _____

Hospital's or Institution's current address _____

City _____ *State* _____ *Zip* _____

Country _____ *Province* _____

Telephone () _____

Describe the condition or problem _____

Describe any treatment and/or monitoring program _____

The Nebraska State Bar Commission is aware of HIPAA requirements.