



Guidelines for Documentation Verification of Visual Disability

In order to fully evaluate requests for accommodations or auxiliary aids, The Office of Learning Support Services requests documentation of the student's visual impairment diagnosis. The documentation should include an evaluation by an ophthalmologist, optometrist, or other appropriate professional that makes evident the current impact of the visual disability as it is related to the accommodation(s) suggested. The documentation should also provide evidence indicating that the criteria for diagnosis have been met.

The outline listed below is developed to assist you with preparing and submitting the information needed to evaluate requests. Each question must be answered in order for the documentation to be accepted. If, after reading these guidelines, you have any questions, feel free to call our office at 419.559.2342.

The following section is to be completed by the diagnosing professional. Please print legibly or type. This information may also be submitted in the form of a clinical narrative:

The following information pertains to:

_____	_____
Last Name	First Name
_____	_____
Social Security #	Date of Birth

1. What is the diagnosis, date of diagnosis, and last contact with the student?
2. Please describe your assessment procedures and evaluation instruments, providing both the quantitative and qualitative information about the student's abilities, including visual acuity, the use of corrective lenses, ongoing visual therapy (if appropriate), etc.
3. Describe the symptoms that meet the criteria for the diagnosis.

4. If applicable, please describe the progression of this disability.

5. Please describe how this visual disability may affect this student both academically and/or physically. What are his/her functional limitations?

6. List current medication(s), dosage, frequency, and possible adverse side effects.

7. What recommendations do you have regarding accommodations (i.e. extra time for exams, enlarged print, books on tape or scanned onto disk, etc.)? Please discuss your rationale for each of the suggested accommodations.

8. Are there any other associated disabilities (e.g. diabetes, Multiple sclerosis, glaucoma, etc.)? What are the functional limitations associated with these disabilities?

Signature: _____

Print name and title: _____

Medical specialty: _____

License #: _____

Address: _____

Telephone: _____

Please complete the following: FUNCTIONAL IMPACT ASSESSMENT

Limitations: 1. Unable to Determine 2. Mild 3. Substantial

1.	2.	3.	Major Life Activity	1.	2.	3.	Major Life Activity
			Caring for oneself				Learning
			Talking				• Reading
			Hearing				• Writing
			Breathing				• Spelling
			Seeing				• Calculating
			Walking/Standing				• Concentrating
			Lifting/Carrying				• Memorizing
			Sitting				• Listening
			Performing Manual Tasks				Other:
			Eating				
			Working				
			Interacting with Others				
			Sleeping				

** Please note: In order for students to receive disability support services, a substantial limitation must exist.*

What method(s) were utilized to assess functional limitation? Please list or attach under separate cover.

**Return this information to: Office of Learning Support Services, Roy Klay Hall
Terra Community College
2380 Napoleon Rd.
Fremont, OH 43420**

Thank you for helping us to provide the support necessary for success this student's success.