DIVISION OF
STUDENT AFFAIRS
COUNSELING CENTER

Accessibility and Disability Service
0106 Shoemaker Building
4281 Chapel Lane
College Park, Maryland 20742
301.314.7682 TEL
301.405.0813 FAX

VERIFICATION OF VISION DISABILITY FOR ACCOMMODATIONS

This form has been established to obtain current information from a qualified practitioner (e.g., optometrist, ophthalmologist) regarding a student's vision disability, and the impact of the disability on the student, and the student's need for accommodations. This Verification Form may supplement information that is provided in other reports, including medical reports or secondary school documentation. It must be completed in order for students to receive vision-related accommodations through the Accessibility and Disability Service (ADS) at the University of Maryland, College Park.

Under the Americans with Disabilities Act (Amendments Act) of 1990(2008) and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations.To establish that an individual is covered under the law, documentation must indicate that a specific disability exists and that the identified disability substantially limits one or more major life activities and has an expected duration of not less than 6-8 weeks. A diagnosis of a disorder in and of itself does not automatically qualify an individual for accommodations. The documentation must also support the request for accommodations and academic adjustments.

Please see the following criteria for documenting a vision disability:

1. Documentation must be relevant and appropriate to the diagnosis. Documentation should include information from within the last twelve (12) months.
2. This form must be completed by an appropriate professional who is credentialed to diagnose vision impairments, such as an optometrist or ophthalmologist. The professional completing this evaluation cannot be a relative of the student or a close family friend.
3. When appropriate, some registered students may be asked to provide periodic updates.

I. Student Information: **(Please Print Legibly or Type)**

Student's Name:

First: _____ Middle: _____ Last: _____

UID #: _____ Date of Birth: _____

Contact number: _____ Email Address: _____

Student's Gender: ☐ Male ☐ Female ☐ Trans/male ☐ Trans/female

☐ Gender queer/non-conforming ☐ Different identity (Please state): _____

II. Provider Section:

1. Contact with Student

a. Date of initial contact with student: _____

b. Date of last contact with student: _____

c. Frequency of appointments with student (e.g., once a week, once a month): _____

2. Diagnosis

a. What is the student's diagnosis?

b. When was the student diagnosed with the condition? Month _____ Year _____

c. What is the severity of the impairment? Mild ☐ Moderate ☐ Severe ☐

i. Explain the level of severity checked above:

d. What is the expected duration of the impairment?

Short-term (<6 months): ☐

Episodic: ☐

Long-term (>6 months-1 year): ☐

Chronic (>1 year): ☐

i. Explain the duration checked above:

e. Current Symptoms:

i. What is the student's current best-corrected visual acuity and visual field in each eye (please explain in detail)?

Visual Acuity (e.g., 20/XX)		Visual Field (e.g., XX degrees)	
Distance	Near	Central	Peripheral

ii. Is the vision loss expected to remain stable or is it expected to decline? If it is expected to decline, please describe the expected progression of the vision loss.

iii. Describe the proficiency of orientation and mobility of the student for independent travel (e.g., proficient in cane usage; uses a service animal; has usable vision; uses GPS technology or other technologies; needs additional O & M training).

iv. Is there clear evidence that the symptoms associated with the vision impairment are interfering with or reducing the quality of at least one of the following, including academic functioning?

Academic functioning:	
Social functioning:	
Work functioning:	

3. Student's History

a. Please include any historical information relevant to the student's vision impairment and associated functioning (e.g., developmental, familial, medical, pharmacological, psychological, psychosocial).

b. Assistive or Adaptive Technology:

i. Are glasses, contacts, or other visual aids prescribed to assist the student's visual acuity? If so, what is the visual acuity with the glasses, contacts, or visual aids?

ii. How does the student access print of materials (e.g., size of enlarged print; Braille; text reader; screen reader)?

iii. If the student currently uses assistive or adaptive technologies to facilitate visual performance, please list specifics related to the brand, model number, and proficiency of and setting for use (e.g., educational, home, work).

4. Functional Limitations and Recommended Accommodations

a. Please list the student's current symptoms associated with the vision impairment and then indicate what reasonable academic accommodations would mitigate the symptom listed.

Example: *Due to vision impairment, the student cannot read written information.*
Symptom: *Visual acuity extremely low*
Recommended Reasonable Accommodation(s): *Reader for tests or use of screen reading program (i.e., JAWS)*

Symptom:
Recommended Reasonable Accommodation(s):

Symptom:
Recommended Reasonable Accommodation(s):

Symptom:
Recommended Reasonable Accommodation(s):

III. Provider's Professional Information:

Professionals conducting the assessment, rendering a diagnosis, and providing recommendations for reasonable accommodations must be qualified to do so (i.e., optometrist, ophthalmologist). The provider signing this form must be the same person answering the above questions.

Provider's Name:

First: _____

Middle: _____

Last: _____

Credentials: _____

License Number: _____

State of Licenser: _____

Street Address: _____

City: _____

State: _____

Zip: _____

Phone Number: _____

E-mail Address: _____

May this completed Verification Form be released to the student? Yes ☐ No ☐

Signature of Provider: _____ Date: _____

Submitting this Form:

This form should be returned to the Accessibility and Disability Service office at the University of Maryland.

(Adapted from the Pennsylvania State University Office for Disability Services 09.2015)