DISABILITY SUPPORT RESOURCES

Grand Valley State University

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www.gvsu.edu/dsr

DISABILITY DOCUMENTATION FORM:

BLINDNESS AND VISUAL IMPAIRMENT

The office of Disability Support Resources (DSR) strives to ensure that qualified persons with chronic health conditions are accommodated, and if possible, that their accommodations do not jeopardize successful therapeutic interventions. The office does not modify requirements that are essential to the program of instruction or provide accommodations for persons whose impairments do not substantially limit one or more major life function.

Grand Valley State University is required by Section 504 of the Rehabilitation Act and the Americans with Disabilities Act to provide effective auxiliary aids and services for qualified students with documented disabilities if such accommodations are needed to provide equitable access to the University's programs and services. Federal law defines a disability as "a physical or mental impairment that substantially limits one or more major life activities." Major life activities are defined as the ability to perform functions such as walking, seeing, hearing, speaking, breathing, learning, working, or taking care of oneself. It is important to note that a chronic health condition in and of itself does not necessarily constitute a disability. The degree of impairment must be significant enough to "substantially limit" one or more major life activities.

This form is designed to allow us to achieve these goals. Persons who wish to receive accommodations due to a chronic health condition need to have this form filled out by a certified physician. The physician completing this form must have first-hand knowledge of the person's condition, must have experience diagnosing and treating condition, and will be an impartial professional who is not related to the patient. **NOTE: Form may not be used as documentation for Assistance Animals.** Please complete all blanks on this document. If any information is left unanswered, this documentation will not be accepted.

The Americans with Disabilities Act (ADA) defines disability as "a physical or mental impairment that substantially limits one or more major life activities, a record of such impairment, or being regarded as having such an impairment." Disabilities involve substantial limitations and are distinct from common conditions not substantially limiting major life activities.

Client Information (to be completed by the client)

Last Name: ____________________ First ____________________ Middle Initial ______

Date of Birth: ________________ Client's GVSU G#: ______________________

Certifying Professional (to be completed by the certifying professional)

Certifying Professional's Full Name: ____

Credentials/Specialization: ____

License Type: ____

License #: ____________________ State ______ Exp. Date ______

Mailing Address: ____

City: ____________________________ State: ____________________ Zip: _____________

Phone Area Code: (_____) Phone Number __________________

Fax Area Code: (_____) Fax Number __________________

Email: ____________________________

Please Attach Business Card Here

OR

If Submitting Electronically,

Denote your Office Web Address

Office web address: ____

Diagnosis/Diagnoses: Please include DSM or ICD Codes and name of condition(s)

____
____
____

Date of onset: ____________ Date of diagnosis: ____________

Visual Acuity (with best correction):

Distance:	OD ______	OS ______	OU _____
Near:	OD ______	OS ______	OU _____
Visual Field:	OD ______	OS ______	OU _____

Other comments about the diagnosis: (e.g. night vision, depth perception, ocular mobility/balance, color perception, etc.):

____
____
____

Prognosis (expected duration, stability, or progression of the condition, etc.):

____
____
____

Treatments, medications, devices, or services currently prescribed or used to address the diagnosis/diagnoses above (e.g. monocular telescope, low-vision devices, long cane, CCTV, use of dog guide, etc.):

____
____
____

From your perspective, describe possible accommodations that could facilitate academic or workplace performance:

____
____
____

Additional comments:

____
____
____

Using the contact information on page one, print, sign below, and fax/send directly to Disability Support Resources.

Date: _________________________

Certifying Professional Signature: ____

Signature denotes content accuracy, adherence to professional standards and guidelines on page 1 of this document.