Vision Disability Verification Form

The Learning Support and Disability Services Department at The College of Idaho provides academic services and accommodations for students with diagnosed disabilities. The documentation provided regarding the disability diagnosis must demonstrate a disability covered under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act (ADA) of 1990. The ADA defines a disability as a physical or mental impairment that substantially limits one or more major life activities. In addition, in order for a student to be considered eligible to receive academic accommodations, the documentation must show functional limitations that impact the individual in the academic setting.

The LSDS Department requires current (no more than three years old) and comprehensive documentation in order to determine appropriate services and accommodations. The outline below has been developed to assist the student in working with the treating or diagnosing healthcare professional(s) in obtaining the specific information necessary to evaluate eligibility for academic accommodations.

A. The healthcare professional(s) conducting the assessment and/or making the diagnosis must be qualified to do so. These persons are generally trained, certified or licensed psychologists or members of a medical specialty.

B. All parts of the form must be completed as thoroughly as possible. Inadequate information, incomplete answers and/or illegible handwriting will delay the eligibility review process by necessitating follow up contact for clarification.

C. The healthcare provider should attach any reports which provide additional related information (e.g. psycho-educational testing, neuropsychological test results, etc.). If a comprehensive diagnostic report is available that provides the requested information, copies of that report can be submitted for documentation instead of this form**.** ***Please do not provide case notes or rating scales without a narrative that explains the results.***

D. After completing this form, sign it, complete the Healthcare Provider Information section on the last page and mail or fax it to us at the address/numbers provided. The information you provide will *not* become part of the student's educational records, but it will be kept in the student's file at LSDS, where it will be held strictly confidential. This form may be released to the student at his/her request. In addition to the requested information, please attach any other information you think would be relevant to the student's academic adjustment.

If you have questions regarding this form, please call the LSDS Department at (208) 459-5141 or email tkazan@collegeofidaho.edu. The LSDS Department fax number is (208) 459-5108. Thank you for your assistance.

STUDENT INFORMATION
(Please Print Legibly or Type)

Name (Last, First, Middle):
_____

Date of Birth: _____ Last 4 Digits of SSN: _____

Status (check one): ☐current student ☐transfer student ☐prospective student

Local phone: (_____) _____-_____ Cell phone: (_____) _____-
_____

Address (street, city, state and zip code):
_____

_____

C of I E-Mail address:
_____@yotes.collegeofidaho.edu

Other E-mail address:
_____

DIAGNOSTIC INFORMATION
(Please Print Legibly or Type)

1. What is the diagnosis, date of diagnosis, and last contact with the student?

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_____

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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.

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3. Describe the symptoms that meet the criteria for the diagnosis.

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4. Describe the progression of this disability of applicable.

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5. Describe how this visual disability may affect this student both academically and/or physically (functional limitations).

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

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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.

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8. Are there any other associated disabilities, e.g. diabetes, M.S., glaucoma, etc., and what are the functional limitations associated with these disabilities?

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_____

_____

_____

HEALTHCARE PROVIDER INFORMATION

(Please sign and date below and fill in all other fields completely using PRINT or TYPE)

Provider Signature: _____ **Date**: _____

Provider Name (Print): _____

Title: _____

License or Certification #: _____

Address: _____

_____

Phone Number: (_____) _____-_____

FAX Number: (_____) _____-_____