VISION DISABILITY VERIFICATION FORM

Services for Students with Disabilities (SSWD) determines reasonable academic 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 receive academic accommodations, the documentation needs to show functional limitations that will impact an individual in an academic setting.

The SSWD Office requires current comprehensive documentation in order to determine appropriate services and accommodations based on functional limitations that may impact the student in the academic setting. The information listed below has been developed to assist the student in working with the treating/diagnosing professional(s) in obtaining the specific and necessary information to evaluate requests for academic assistance based on the diagnosis.

All information requested must be completed as thoroughly as possible. Inadequate information and/or incomplete forms will delay the eligibility review process. All answers to the questions on the form must be legible. It is recommended that answers to the form be typed; illegible handwriting will delay the eligibility review process since the provider will be contacted for clarification.

The professional(s) conducting the assessment and making the diagnosis must be qualified to do so. Qualified professionals to diagnose vision impairment include: ophthalmologist, optometrist, and neurologist.

The information provided will not become part of the student’s educational records and will be kept in the student’s confidential file at the SSWD Office.

The ADA Coordinator in the Distance Learning Center is the authorized liaison between the two offices. The student’s point of contact will be Marcia Rako – ADA Coordinator. Marcia can be reached at rakom@uwplatt.edu or 800-362-5460.
DIAGNOSTIC INFORMATION
(Please Print Legibly or Type)

Student name: ___________________________ Date: __________________

Please attach an ocular assessment or evaluation from an ophthalmologist and any other 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 discusses the results.

1. What is the diagnosis? ____________________________________________

2. What is the date of diagnosis? ____________________________________

3. When did you last see the student/patient? __________________________

4. Is the student/patient currently under your care? ☐ Yes ☐ No

5. A student must have a substantial limitation in a major life activity to receive accommodations at the post secondary level.
   Severity of the vision loss (check one): ☐ mild ☐ moderate ☐ substantial
   Describe the severity checked above:
6. 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. and/or attach a copy of a current ocular assessment or evaluation from an ophthalmologist; a low-vision evaluation of residual visual functions, when appropriate.

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

8. Describe the progression/history of this condition (historical summary).

9. Describe how this visual disability may affect this student both academically and/or physically (functional limitations).
10. List current medication(s), dosage, frequency, and adverse side effects.

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

12. What recommendations do you have regarding accommodations and/or auxiliary aids in an academic setting? State your rationale for the accommodations and/or auxiliary aids you have recommended.
13. Is there anything else that you would like us to know about this student?
PROVIDER INFORMATION
(Please sign and complete fully in Print or Type)

Description of the author’s credentials which indicates their qualification to diagnosis a vision disability.

Signature: __________________________ Date: ________________

Print Name and Title: _____________________________________________

License or Certification #: _________________________________________

Office Address (street, city, state and zip code):
___________________________________________
___________________________________________
___________________________________________

Office phone: (______)-_______-___________

FAX Number: (______)-_______-___________

Email__________________________________

These guidelines are not meant to be used exclusively or as a replacement for direct communication with UW-Platteville Services for Students with Disabilities regarding the individual nature of a disability. While submitted documentation meeting the above guidelines may be acceptable to the University of Wisconsin-Platteville it is important to be mindful that they may/may not meet the documentation guidelines required in other academic or testing organizations.