



2420 Nicolet Drive, Student Services 1700, Green Bay, WI 54311

Tel: (920) 465-2841

Fax: (920) 465-2191

LOW VISION AND BLINDNESS

To ensure the provision of reasonable and appropriate accommodations, students requesting services must provide **current** documentation of their disability. This documentation should provide information regarding the onset and severity of the disability, as well as describe how it interferes with educational achievement. In order to establish that an individual is covered under ADAAA and Section 504 of the Rehabilitation Act of 1973, documentation must demonstrate that the individual has a disability and that it substantially limits some major life activity, including learning. The documentation must show how the disability impacts the major life activity of learning, and if you are requesting accommodations, academic adjustments and/or auxiliary aids, the documentation must support your request.

The student named below has applied for services from the Disability Services (DS) Office at UWGB. In order to provide reasonable and appropriate services for students with low vision and blindness, current and comprehensive information documenting the functional impact of the disability is required. This form is intended to assist clinicians in providing sufficient information so that eligibility for services can be determined. The information you provide will not become part of the student's educational records and will be kept in the student's confidential file at DS Office. In addition to the requested information, please attach any additional information; for example, your report and any test results. Thank you for your assistance.

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 _____

Return to:

UW – Green Bay

Disability Services

2420 Nicolet Dr., SS1700

Green Bay, WI 54311

Fax: (920) 465-2191

Email: dis@uwgb.edu