KENT STATE UNIVERSITY

DISABILITY VERIFICATION Blindness/Low Vision & other Visual Disorders

Please read the following prior to completing this form:

Student Accessibility Services at Kent State University provides support services to students with diagnosed disabilities, including blindness/low vision and other visual disorders. To ensure the provision of reasonable and appropriate accommodations for our students, this office requires **comprehensive, and depending on the specific disability, current documentation of the disorder from their diagnosing/current ophthalmologist or optometrist.** This should include information that describes the symptoms and manifestation of the condition, medication prescribed, and recommendations for treatment.

***NOTE:** Student Accessibility Services (SAS) reserves the right to make appropriate modifications to the above time frame required for current documentation when necessary.*

For additional information about SAS please email: cjone154@kent.edu

Please provide the following information about (student name):_____

1. Diagnosis:

   Date of Diagnosis: _____ Last contact with student:

   Is the student/patient currently under your care? _____ YES _____ NO

2. Please provide the student's **best-corrected visual acuity and date** this was recorded: _____

3. Please describe the student's **visual field limitations**, if applicable: _____

4. Describe the **symptoms** associated with this condition: _____

5. Describe the **student/patient's prognosis** for this condition: _____

6. List **current medication(s), dosage, frequency and possible adverse side effects** as related to academic performance, if applicable: _____

7. Describe how this condition **substantially limits a major life activity** and **how it may impact the student/patient's progress** in an academic setting: _____

8. List any **recommendations for accommodations** you have for this student/patient in an academic setting:

9. Please describe any specific concerns you may have, or other ways that we may be of further assistance to this student/patient: _____

Healthcare Provider Information

Provider Name and Title: _____

Provider Signature: _____ Date: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Phone: ( )_____

The information you provide in this document is maintained in the office of Student Accessibility Services at Kent State University according to the guidelines of the Family Educational Rights and Privacy Act (FERPA).

Please mail or fax this completed form to:

Student Accessibility Services · Kent State University, Ashtabula · Library · Ashtabula, OH 44004-0001
phone: (440) 964-4232 **fax:** (440) 964-4573 **e-mail**: cjone154@kent.edu