CONFIRMATION OF VISUAL DISABILITY
For the California State University Foundation

A **disability** shall mean a physical or mental impairment of an individual that limits one or more of the major life activities and requires either a record of such an impairment, or documentation of having been regarded as having such an impairment.

Visual limitation: Blindness or partial sight to the degree that it impedes the educational process and necessitates accommodations, support services, or programs.

Consumer/Client/Patient:

Name: _____ Date of Birth: _____

Address: _____

Best Corrected vision: OD (right eye) _____ OS (left eye) _____

OU (both eyes) _____

Visual Field (in degrees): _____

Specific eye condition(s): _____

Certifying Authority:

I certify that _____ has a visual disability as specified above.

(Signed) _____ *(Date)* _____

(Title) _____

Print/type your name, profession, and address here:

Name: _____ Profession: _____

Address: _____