CONFIRMATION OF VISUAL DISABILITY

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 (please complete the following form only if patient is eligible based upon the definition of **Visual Limitation** above)**:**

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

*(Signed)*_____*(Date)*_____

*(Title)*_____

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