Office of Disability Services
2121 Euclid Avenue MC 147
Cleveland, Ohio 44115-2214
Phone: (216) 687-2015
FAX: (216) 687-2343
www. csuohio.edu/disability/

Vision Disability Verification Form

The Office of Disability Services (ODS) provides academic services and accommodations for student with diagnosed disabilities. The documentation provided 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 or a student to be considerate eligible to receive academic accommodations, the documentation must show the functional limitations that impact the individual in the academic setting.

The ODS requires current and comprehensive documentation to determine appropriate services and accommodations. As a guideline, Cleveland State University generally requires documentation prepared within the past three years. The University reserves the right to request updated or more extensive evaluations. The outline below has been developed to assist the student in working with the treating or diagnosing healthcare profession(s) in obtaining specific information necessary to evaluate eligibility for academic accommodations.

- The healthcare profession(s) conducting the assessment and/or making the diagnosis must be qualified to do so. These persons are trained, certified or licensed ophthalmologists, optometrists, family physicians, or other medical specialist.
- All parts of the form must be completed as thoroughly as possible.
- The healthcare provider should attach any reports which provide additional related information. 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.
- After completing this form, sign it, complete the healthcare Provider Information section, on the last page, and mail or FAX it to us at the address provided above. The information that you provide will NOT become part of the student's educational records, but it will be kept in the student's file at ODS, where it will be held strictly confidential.

STUDENT INFORMATION

First Name: _____ Middle: _____ Last: _____

Date of Birth: _____ Last 4 digits of SSN _____

Local Phone (___) _____-_____ Cell Phone (___) _____-_____

Address (street, city, state, and zip code): _____

Diagnostic Information

1. What are the diagnosis, date of diagnosis, and the last contact with the student?
   _____
   _____
   _____

2. Describe the symptoms that meet the criteria for the diagnosis?
   _____
   _____
   _____

3. Describe the progression of this disability, if applicable:
   _____
   _____
   _____
   _____

4. Describe how this visual disability may affect this student both academically and/or physically (functional limitations).
   _____
   _____
   _____
   _____
   _____

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

_____
_____
_____
_____
_____

6. What recommendations do you have regarding accommodations, i.e. extra time for exams, enlarged print, books on tape or scanned onto disk, etc. Please discuss your rationales for each of the suggested accommodations.

_____
_____
_____
_____
_____
_____
_____

HEALTHCARE PROVIDER INFORMATION

Please sign and date below and fill in all other fields completely. Please print or type.

Provider's signature: _____ Date: _____

Provider's name (print): _____

Title: _____

License or Certification #: _____

Address:

_____
_____
_____

Phone number: (___) _____-_____ FAX number: (___) _____-_____