# 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:**