UNLV | DISABILITY RESOURCE CENTER

University of Nevada, Las Vegas
Disability Resource Center
4505 S. Maryland Parkway
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Phone 702-895-0866
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Vision Disability Verification Form

The Disability Resource Center (DRC) provides academic services and accommodations for students with diagnosed disabilities. It is the student's responsibility to provide documentation that identifies a diagnosed disability covered under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act (ADA) of 1990.

DRC requires current and comprehensive documentation in order to determine appropriate services and accommodations. The outline below has been developed to assist the student in working with the treating or diagnosing healthcare professional(s) in obtaining the specific information necessary to evaluate eligibility for academic accommodations.

- The healthcare professional(s) conducting the assessment and/or making the diagnosis must be qualified to do so.
- Forms must be completed as thoroughly as possible. Inadequate information, incomplete answers and/or illegible handwriting will delay processing and result in follow up contact with the healthcare professional.
- The healthcare provider should attach any reports which provide additional related information (e.g. psycho-educational testing, neuropsychological test results, etc.). **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.**
- Please do not provide case notes or rating scales without a narrative that explains the results.
- In addition to the requested information, please attach any other information you think would be relevant to the student's need for academic adjustments.
- Complete the Healthcare Provider Information section on the last page and mail or fax it to the address provided above.
- If you have questions regarding this form, please call the DRC office at 702-895-0866.

**This document was adapted with permission from Office for Disability Services, The Ohio State University.*

STUDENT SIGNED CONSENT FOR RELEASE OF INFORMATION
(Print or Type)

Name (Last, First, Middle): _____

Date of Birth:_____ NSHE:_____

Status (check one): ☐ Current UNLV student
☐ Transfer student
☐ Prospective student

Local phone: (_____)-_____-_____

Cell phone: (_____)-_____-_____

UNLV E-Mail address: _____

Personal E-mail address:_____(for non-admitted students)

I hereby authorize my Healthcare Provider to release information requested in this document and further authorize DRC to communicate with the named individual or agency identified below to obtain clarification as needed to determine my eligibility for disability services at UNLV. This authorization is valid for 6 months.

Student
Signature _____ Date:_____

Parent Signature
(If student is under 18):_____Date: _____

DIAGNOSTIC INFORMATION

(Please Print Legibly or Type)

Please provide responses to the following items by typing or writing in a legible fashion. Illegible forms will delay the documentation review process for the student.

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

_____

_____

_____

_____

2. Please describe your assessment procedures and evaluation instruments providing both quantitative and qualitative information about the student's abilities including visual acuity, visual field, the use of corrective lenses, ongoing visual therapy (if appropriate), etc.

3. Describe the symptoms experienced by the individual that meet the criteria for the diagnosis.

4. Is the condition stable at this time? If the condition is expected to decline, describe the expected progression of the vision loss.

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

6. List current medication(s), dosage, frequency, and adverse side effects.

7. What **suggestions** do you have regarding accommodations, i.e. extra time for exams , enlarged print, books in audio format or scanned onto disk, etc.? Please discuss your **rationale** for each of the suggested accommodations.

_____

_____

_____

_____

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

_____

_____

_____

_____

HEALTHCARE PROVIDER INFORMATION

Provider Signature:_____ **Date**: _____

Provider Name (Print): _____

Title:_____ **License or Certification #:** _____

Address: _____

_____

Phone Number: **(_____)-_____-_____**

FAX Number: **(_____)-_____-_____**

The information you provide will *not* become part of the student's academic records, but it will be kept in the student's file at DRC, where it will be held strictly confidential. Files are purged after 7 years in compliance with state requirements. This form may be released to the student at his/her request.