Boston University Disability & Access Services

Disability Verification Form – Visual Impairments

The Disability & Access Services provides academic accommodations and services to students with **Visual Impairments**. Students seeking accommodations must provide appropriate documentation of their disability so that the Disability & Access Services can determine the student's eligibility for accommodations; and if the student is eligible, determine appropriate academic accommodations. The documentation must describe a disabling condition, which is defined by the presence of significant limitations in one or more major life activities. Submitting evidence of a diagnosis, or a prescription alone, is not sufficient to warrant academic accommodations. Documentation from a known organization, for example Massachusetts Commission for the Blind, recognizing a student as "legally blind" or eligible for services may be considered, however, specific accommodation requests might require the additional documentation outlined below.

To verify the disability and its severity, the Disability & Access Services requests the following current documentation from an ophthalmologist, optometrist or other qualified professional with experience and expertise in the area related to the student's disability should make the diagnosis.

Documentation should include:

- A **current** clear statement of disability including diagnosis**.** Current documentation is dependent upon the student's condition and the nature of the student's request for accommodations. Documentation should also note the status of the individual's impairment (static or progressive).
- Disabilities that are sporadic or change over time may require more frequent evaluations. Documentation that reflects the *current* impact on the student's functioning should be submitted. **Present symptoms** that meet the criteria for the diagnosis must be present and noted.
- A narrative clinical summary of assessment procedures that were used to make the diagnosis, evaluation results, history of disability, and a list of recommended accommodations.
- A description of how current functional limitations will present in an academic environment.
- Suggested accommodations to address each limitation.
- The diagnostic report must include the ***name, and title, and license number*** of the evaluator.
- A complete Disability Verification Form (please do not write "see attached")

Further assessment by an appropriate professional may be required if co-existing learning disabilities or other disabling conditions are indicated. All documentation must be submitted on the official letterhead of the professional describing the disability. The report should be dated and signed and include the name, title, and professional credentials of the evaluator, including information about license or certification. The Disability & Access Services will make the determination regarding whether accommodations are reasonable in the University environment.

All documentation is considered confidential and can be mailed or faxed to:
Disability & Access Services
25 Buick Street Suite 300
Boston, MA 02215
Phone: 617-353-3658

Fax: 617-353-9646
access@bu.edu
www.bu.edu/disability

Boston University Disability & Access Services

Disability Verification Form – Visual Impairments

This form is intended to assist your client in meeting the documentation requirements for requesting academic accommodations on the basis of a **Visual Impairments** at Boston University. Please fill out all of the questions on the below form, even if the material has been included in your full evaluation and/or clinical summary. The documentation must describe a disabling condition, which is defined by the presence of significant limitations in one or more major life activities. Submitting evidence of a diagnosis, IEP or prescription alone, is not sufficient to warrant academic accommodations.

To ensure the provision of reasonable and appropriate accommodations, students requesting academic accommodations must provide current documentation of their disability. Current documentation is dependent upon the student's condition and the nature of the student's request for accommodations. It should also note the status of the individual's impairment (static or progressive); a changing nature of functionality may need to be documented more frequently.

This documentation should provide information regarding the **onset**, **duration** and **severity** of symptoms, as well as the specifics describing how it has interfered with educational achievement. Please include a copy of all assessments used in making diagnosis.

Please note: All appropriate documentation must be received prior to formal review process commencing. Also, please be aware that provision of accommodations in high school, other non-BU academic institution or on any standardized test does not guarantee that the same or any accommodations will be awarded at Boston University.

All information will be kept confidential. Please feel free to contact the Disability & Access Services at (617)353-3658 with any questions.

Student name:
Signed:_____Date:_____
Name: (please print)_____ BU ID:_____

For the current treating healthcare provider to complete:
1. Diagnosis: Please list all relevant diagnoses.
_____
a. Approximate onset of diagnosis
- ☐ Child - approximate age:_____
- ☐ Adolescent - approximate age: _____
- ☐ Adult - approximate age: _____

b. Date of your last clinical contact with student:_____/_____/_____

2. Evaluation
a. How did you arrive at this diagnosis?
- ☐ Medical evaluation

☐ Structured or unstructured interviews with student.
☐ Interviews with other persons (i.e. parent, teacher, therapist).
☐ Behavioral observations.
☐ Standard eye exam.
☐ Low vision eye exam.
☐ Specialized eye exam: Specify _____

b. Evaluation Results

_____

_____

c. Current treatment being received by student:

☐ Medication management:
Current medications: _____
☐ Physical/Occupational therapy
Frequency: _____
☐ Other (please describe): _____

d. Severity of symptoms:

☐ Mild
☐ Moderate
☐ Severe

e. Visual acuity _____

f. Prognosis of disorder:

☐ Good
☐ Fair
☐ Poor

3. Functional Limitations Y☐ N☐ If yes, please describe: _____

_____

_____

_____

a. Please describe in detail any functional limitations that fall into the significant range.

_____

_____

_____

b. Please list current medications and treatment history.

_____

_____

_____

_____

c. Special considerations, e.g. medication side effects:

_____

_____

_____

4. Coexisting Conditions

Please provide details about any coexisting medical or psychiatric conditions.
Please include all relevant reports.

_____

_____

5. Past Accommodations

Please mark whether student has utilized accommodations in the past. Y☐ N☐
Please describe:_____

_____

_____

6. Suggested Accommodations

Please list the specific academic accommodations you suggest based on your assessment of the students clinical and academic history and diagnosis. _____

_____

_____

_____

7. Technology

a. Was the student given an Assistive Technology Evaluation? Y ☐ N☐

If so, please also attach report.

b. What technology has been utilized in the past?

_____

_____

c. Please list any **technology** related accommodations_____

_____

_____

8. (Optional) Please provide any additional information you feel will be useful in determining the nature and severity of the student's disability, and any additional recommendations that may assist in determining appropriate accommodations and interventions:

_____

_____

_____

Thank you for your help in providing this information so that we may begin services as soon as possible. Please complete the provider information below. This form should be signed and returned to ODS at the address shown at the end of this document.

PLEASE NOTE: To provide documentation of a **Visual Impairment**, the diagnosing professional must be a physician or other medical specialist with experience and expertise in the area related to the student's disability should make the diagnosis.

Provider Information

I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above.

If filling out online, in lieu of signature, please click here to certify that the above statement is true.

Y ☐ N ☐

Signature: _____ Date: _____

Print Name and Title: _____

State of License_____: License Number:_____

Address: _____

Street or P.O. Box City State Zip: _____

Phone: _____Fax:_____

Please return this signed form to:

Disability & Access Services,
25 Buick Street Suite 300
Boston, MA 02215
Phone: 617-353-3658
Fax: 617-353-9646