Academic Affairs • Office of Student Accessibility Services
118 Beacon Street • Boston, MA 02116
Phone (617) 670-4429 • Fax 617-670-4439

Disability Verification Form – Vision Impairment

Student Name:____Date:____________________

Address:__________________________________City:________________________State:_________

Phone:____________________Email:_______________________Student ID#:___________________

Diagnosis:________________________*Date of First Diagnosis*:_____________________

Date of last Clinical Contact:______________________

*Prognosis/Changes:*___________________________

What is the functional limitation in the academic setting:_____Mild______Moderate______Severe

Describe the symptoms (include duration/frequency) of the disorder, how it impacts the student functioning in an academic setting and what might exacerbate these symptoms.

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What medications have been prescribed and are there any side effects that may impact the student's academics (Students who are taking medications must inform the College's Nurse)

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Recommendations for accommodations given the specific disability (Accessibility Services will consider this to determine services):

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Professional's Name/Title (Print):________________________________Phone: _____________________

Address:_______________________________City:________________________State:___________

Signature:________________________________Date:_______________________

This form must be submitted along with current diagnostic evaluations completed within the past 6 months.