Verification Form for Low Vision/Blind Disabilities

Calvin College

Services to students with disabilities, as part of the Center for Student Success strives to ensure that qualified students with low vision/blind disabilities are accommodated and if possible that these accommodations do not jeopardize successful therapeutic interventions. The office does not modify requirements that are essential to the program of instruction or provide accommodations for persons whose impairments do not substantially limit one or more major life function.

Calvin College is required by Section 504 of the Rehabilitation Act and the Americans with Disabilities Act to provide effective services for qualified students with documented disabilities if such accommodations are needed to provide equitable access to the College programs and services. Federal law defines a disability as a physical or mental impairment that substantially limits one or more major life activities. Major life activities are defined as the ability to perform functions such as walking, seeing, hearing, speaking, breathing, learning, working, or taking care of oneself. It is important to note that a low vision/blind condition in and of itself does not necessarily constitute a disability. The degree of impairment must be significant enough to substantially limit one or more major life activities.

This form is designed to allow us to achieve these goals. Students who wish to receive academic adjustments due to a low vision/blind disability need to have this form filled out by an **ophthalmologist**. The professional completing this form must have first hand knowledge of the students' condition, must have experience diagnosing and treating college students and will be an impartial professional who is not related to the student.

Release of Information

I, _____, hereby authorize the exchange and release of the following confidential information to the Center for Student Success and Calvin College for the purpose of determining my eligibility for educational accommodation.

_____ _____

Date Student's Signature

Student Information (This section to be completed by the student)

Last Name _____ First Name _____ MI ___

Student ID# _____ Date of Birth _____

Address _____ Phone _____

City _____ State _____ Zip Code _____

Certifying Professional

Name _____

Credentials _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

License/Certification number and state of license _____

Signature: _____

Date of initial contact with student _____ Date of last contact _____

Diagnosis:

_____

_____

Date of Diagnosis _____

Basis on which diagnosis was made _____

_____

_____

Current medications including dosage and side effects _____

_____

Long-term treatment plan _____

_____

Current compliance with treatment plan: Yes □ No □ Other _____

Prognosis for treatment plan (Include likelihood of improvement or further deterioration and within what approximate time frame.) _____

_____

Planned therapeutic interventions _____

_____

Prognosis for therapeutic interventions (Include likelihood for improvement or further deterioration and within what approximate time frame.) _____

_____

Current compliance with therapeutic interventions: Yes □ No □ Other _____

History of hospitalization _____

_____

Implications for Educational Success

Learning abilities specific to the post-secondary environment that are impaired by the disability. (e.g. difficulty with concentration, slow processing speed, etc.)

_____

_____

Implications for taking exams and other classroom activities caused by the disability or medications. Please describe and explain why:

Suggested accommodations Each recommended accommodation should include a detailed explanation of its relevance to the disability that is diagnosed. Evaluator also should indicate the level of impaired functioning at which the individual is currently functioning even with the benefits of treatment. Please send a report from an ophthalmologist.

(Final determination of appropriate accommodations will be determined by our office in accordance with the mandates of the Rehabilitation Act of 1973 and the Americans with Disabilities Act as well as court rulings and Department of Education Office of Civil Rights rulings related to these two laws.)

This form should be returned to:

Calvin College
Center for Student Success
Attn:Disability Services
1820 Knollcrest Circle SE
Grand Rapids, MI 49546

Phone #: (616) 526-6155
Fax #: (616) 526-7066