Georgia State University | DISABILITY SERVICES
DIVISION OF STUDENT AFFAIRS

Documentation for Vision Loss & Blindness

Georgia State University's Office of Disability Services provides academic services and accommodations for students with documented disabilities. The treating or diagnosing healthcare professional should complete this form. Disability Services will use this form to evaluate eligibility for academic accommodations, which includes 1) disability diagnosis as defined under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act (ADA) of 1990, as amended (ADAAA); 2) aid in the determination of appropriate services and accommodations in the academic environment.

The information provided by the health care professional will not become part of the student's educational records, but will remain in the student's confidential file in Disability Services. Upon request, this form may be released only to the student. In addition to the requested information, please attach any other information you think would be relevant to the student's academic adjustment.

After completing this form, sign it, complete the Healthcare Provider Information section on the last page and return it to the student, who will give it to the Disability Services Provider at Georgia State University.

Date _____ Print Name _____ Student ID# _____

Primary Diagnosis: _____

Date of onset:

Secondary Diagnosis (if any)**:** _____

Date of onset:

Date of last visit: *

Describe the history and current status of vision or blindness, and any symptoms or accompanying conditions. Attach ocular report for current vision status if using residual vision.

_____

_____

_____

_____

_____

Describe current functional limitations, which affect this student in the academic setting, and suggestions for accommodations (i.e., magnification/CCTV, or extra time).

Limitations	**Recommendations**
_____	_____
_____	_____

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*The information in this document should be based on medical evaluation not older than three (3) years from the date of request for services, unless the condition is of a permanent and non-varying nature.

Healthcare Provider Information (In the space provided, please attach a business card.)

Provider Signature_____ Date_____

(Please print)

**Provider name:_____ Title:_____ License #:_____

Attach Business Card Here