VERIFICATION OF VISUAL DISABILITY*

To be completed by an Ophthalmologist. A separate Ophthalmological report, which includes the equivalent information, may also be acceptable.

Student Name ___________________________ Student Number ___________________________

1. a) Diagnosis and current associated symptoms:

   b) Best corrected visual acuity:

   c) Description of visual fields:

2. a) Date of onset of this disability: __________________________

   b) Date the student was first seen by you for this disability: __________________________

   c) Date of most recent appointment: __________________________

   d) Will you be regularly monitoring this patient’s condition? Y N
      - If yes, how often?

3. Prognosis. The patient’s disability is currently considered:

   □ Permanent – ongoing symptoms expected for the duration of natural life
   □ Permanent – recurring episodes with relatively symptom-free periods of remission
   □ Chronic (present for the past year and likely to persist for at least one more year)
   □ Temporary
      □ estimated recovery date: __________________________ and/or
      □ requires periodic re-assessment. Next assessment date: __________________________

*For purposes of this form, a disability is defined as a medical condition or a physical, neurological or sensory impairment which may be permanent or temporary and is likely to continue and may significantly interfere with educational pursuits AND the student experiences functional limitations in their ability to perform the range of life’s activities AND may experience attitudinal and/or environmental barriers that hamper their participation in life.
4. Please check all boxes that apply regarding the current functional impact of this disability:

<table>
<thead>
<tr>
<th>Activity</th>
<th>No impact</th>
<th>No impact with use of standard lenses</th>
<th>No impact with use of additional aids/technologies</th>
<th>Persisting limitations despite lenses/technology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reading standard print</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Distance viewing (e.g., viewing blackboard or overheads)</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Writing</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Using a computer</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Mobility</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Safety (e.g., handling lab equipment or volatile materials)</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Other (please specify):</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

6. If this patient is currently taking medication or treatment for this disability, what impact, if any, will it have on the student’s academic functioning?

7. What technology or strategies, if any, does the student currently use to support their vision?

8. Are there any suggestions for other types of visual support(s)?

**Certification of Qualified Assessing Professional:**

Signature of Professional ____________________________ Date ____________________________

Name of Professional (printed) and Title ____________________________ License Number ____________________________
Student’s Informed Release:

The information on this form is collected under the general authority of the University Act (R.S.B.C. 1996, c.468, s.27(4)(a)) and Simon Fraser University Policy GP-26, Accessibility Policy for Students with Disabilities. It is related directly to and needed by the University for verification of disability to receive service support from the Centre for Students with Disabilities. The information will be used only for services directly related to your studies at Simon Fraser University. If you have any questions about the collection and use of this information please contact the Director, SFU Centre for Students with Disabilities, 778-782-3313.

In addition to the personal information collected on this form we may need to collect additional personal information about you from your health care practitioner(s) (e.g., doctor, psychologist). These persons or organizations are authorized to disclose such information. The personal information collected from these persons or organizations relates specifically to the disability and services or equipment required because of the disability. This information is collected and used for the same purposes as noted above.

By signing below I agree to the terms and conditions of CSD registration and authorize the CSD to collect, use and share personal information about me as noted above. I understand that failure to agree and give my authorization will result in an inability for the CSD to adequately provide services or academic accommodations required because of my disability.

I, _____________________________ authorize the above-named physician to release this Verification of Visual Disability form to the Centre for Students with Disabilities at Simon Fraser University.

Student’s Signature:___________________________________ Date: _____________________