Disabilities Services
Verification Form for Students with Blindness and Low Vision

This form is intended to assist in meeting our documentation requirements for these disabilities. However, if not thoroughly completed, it may not be sufficient as the sole form of documentation provided. The acceptable age of the documentation is dependent upon the nature of the condition. In cases where the condition is permanent or unchanging Disabilities Services (DS) may require current functional limitation from a qualified provider. This documentation should provide information regarding the onset, longevity and severity of symptoms, as well as the specifics describing how it has interfered with educational achievement. To standardize our gathering of information, it is recommended that you complete the following questions, even if the material has already been included in your full evaluation. All information will be kept confidential. Please feel free to contact the DS at (405) 789-7661 Ext: 3424 with questions.

The information below is to be completed and signed by the student.

I request and authorize Southwestern Christian University at Bethany, Oklahoma, and Disabilities Services and/or my off-campus provider (name) ____________________________ to release, fax, mail or discuss with each other information related to my registering with Disabilities Services (DS).

Student Name ___________________________________________ EID ___________________________

Student Signature _________________________________________ Date __________________________

Email Address: ___________________________________________ Phone Number: _______________________

If the information above is left blank or is incomplete it may delay or prevent DS from contacting the student to verify receipt of the documentation and provide next steps for completing the registration process.
The information below is to be completed and signed by the Provider.

1. Diagnosis: Please list all diagnoses and supporting numerical assessments of vision.

Visual Acuity with correction: ________________________________

Visual Acuity without correction: ________________________________

a. Approximate onset of diagnosis
   - Child-approximate ________________________________
   - Adolescent-approximate ________________________________
   - Adult-approximate ________________________________

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

2. Evaluation
   a. How did you arrive at this diagnosis? Please check all relevant items below, adding brief notes that you think might be helpful to us as we determine eligibility for accommodations.
      - Medical evaluation (x-ray, lab work, EKG, etc.).
      - Specialized eye exam: ________________________________
      - Structured or unstructured interview with student.
      - Interviews with other persons (i.e. parent, teacher, therapist)
      - Behavioral observations.

b. Evaluation Results

   ________________________________

   ________________________________

   ________________________________

c. Present symptoms that meet criteria for diagnosis being noted.

   ________________________________

   ________________________________

   ________________________________
d. Current treatment being received by student:
   - Medication
     Current medications: ________________________________
   - Other (please ________________________________

c. Severity of symptoms
   - 
   - 
   - 

f. Prognosis of disorder:
   - good (vision loss is
   - fair (vision loss is changing but individual retains functional level of
     sight)

3. Functional Limitations

   a. Does this condition significantly limit one or more of the following major life activities?

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<th></th>
<th>No Impact</th>
<th>Moderate Impact</th>
<th>Substantial Impact</th>
<th>Don't Know</th>
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<td>Communicating</td>
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<td>Hearing</td>
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<td>Learning</td>
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<td>Manual Tasks</td>
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<td>Reading</td>
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<td>Other:</td>
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b. Please check the **functional limitations or behavioral manifestations** for this student:

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<th>Not an Issue</th>
<th>Moderate Issue</th>
<th>Substantial Issue</th>
<th>Don't Know</th>
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<td>Cognitive Processing</td>
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<td>Memory</td>
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<td>Processing Speed</td>
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<td>Meeting Deadlines</td>
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<td>Attending class</td>
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<td>Organization</td>
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<td>Reasoning</td>
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<td>Stress</td>
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c. Please describe in detail any functional limitations that fall into the substantial range.

________________________________________________________________________

________________________________________________________________________

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

________________________________________________________________________

________________________________________________________________________

4. **Accommodations**

a. Please mark whether student has utilized accommodations in the past.

   o **Yes Please**

   o

   o **Don't**
b. (Optional) Recommended educational accommodations:


c. (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 on the next page. This form should be signed and returned via fax or mail to the DS office at the address shown at the end of this document.

All documentation submitted to DS is considered confidential.

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.

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 form to:
Southwestern Christian University at Bethany, OK
Disabilities Services
7210 NW 39th Expy
Bethany, OK 73008-3637
Phone: (405) 789-7661
Fax: (405) 495-0078
VP: (405) 789-7661 Ext: 3424

Attach Provider Business Card Here