Southeast Arkansas College
Office of Disability Services
1900 Hazel
Pine Bluff, Arkansas 71603
Phone 870-543-5949 Fax 870-373-5107

Vision Disability Verification Form

The Office of Disability Services (ODS) provides academic services and accommodations for students with diagnosed disabilities. The documentation provided must demonstrate a disability covered under Section 504 of the Rehabilitation Act of 1973 and the Title II of the Americans with Disabilities Act (ADA) OF 1990. The ADA defines a disability as a physical or mental impairment has substantially limits one or more major life activities. "Major life activities" include caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, sitting, standing, lifting, and working, as well as mental and emotional processes such as thinking, concentrating, and interacting with others. For a student to be considered eligible to receive academic accommodations, the documentation must show the functional limitations that impact the individual in the academic setting.

The ODS requires current and comprehensive documentation to determine appropriate services and accommodations. As a guideline, Southeast Arkansas College (SEARK) generally requires documentation prepared within the last three (3) years. SEARK reserves the right to request updated or more extensive evaluation. The outline below has been developed to assist the student working with the treating or diagnosing healthcare professional(s) in obtaining the information necessary to evaluate eligibility for academic accommodations

- The healthcare professional(s) conducting the assessment and/or making the diagnosis must be a qualified practitioner. These persons are generally trained, certified or licensed ophthalmologists, optometrists, family physicians, or other medical specialist.
- All parts of the form must be completed as thoroughly as possible.
- The healthcare provider should attach any reports which provide additional, related information. If a comprehensive diagnostic report is available that provides the requested information, copies of that report can be submitted for documentation instead of this form.
- **After completing this form, sign it, complete the healthcare provider information section on the last page and mail or fax it to the ODS at the address provided above on this form.** The information provided will NOT become part of the student's educational record, but it will be kept with the student's file at ODS, where it will be held strictly confidential.

STUDENT INFORMATION

First name_____ Middle_____ Last_____

Date of birth_____ Last four digits of SSN_____

Status (Check one) __current student __transfer student __ prospective student

Cell phone (____) _____-_____ Local phone (____) _____-_____

Address_____

_____

Diagnostic Information

Please provide the following information:

1. Date of Diagnosis_____

2. Date of first contact with the student: _____

3.Date of last contact with student: _____

4 Describe they symptoms that meet the criteria for the diagnosis.

_____
_____
_____
_____
_____

5. Describe the progression of this disability, if applicable:

_____
_____
_____

6. Describe how this visual disability may affect this student both academically and/or physically (functional limitations).

_____
_____
_____
_____

10. Are there any other associated disabilities, e.g. Diabetes, M.S., glaucoma, etc., and what are the functional limitations associated with these disabilities?

_____
_____
_____
_____
_____
_____

12. What recommendations do you have regarding accommodations, i.e. extra time for exams, enlarged print, books on tape or scanned onto disk, etc. Please discuss your rationales for each of the suggested accommodations.

_____
_____
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_____
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_____

Health Care Provider's Signature Information

Print, sign, and date below and fill in the other fields completely. *Please print or type*

Provider's name(Print)_____

Provider's signature: _____ Date_____

Title: _____

License or Certification #_____

Address:

_____

_____

_____

Phone number (___) _____-_____ Fax number (___) _____-_____