Disability Support Services
Lesley University
(617) 617-349-8655 (via Relay 711)
(617) 649-3704 (fax)
dss@lesley.edu

For Office Use Only

Date Received:

Blind or Legally Blind Disclosure Form

The licensed clinician or health care provider **who is treating this patient for the diagnosis identified** in this document **must** complete this form.

INCOMPLETE FORMS WILL DELAY POTENTIAL SERVICES

Student's Name: _____ Date: _____

Clinician's Name: _____

State Licensure/ Certification #: _____

Area of Specialty: _____ Clinician's phone #: _____

Address: _____

The person named on this form is requesting accommodations from Disabilities Support Services, which offers services to students who are considered disabled under the mandates of the Americans with Disabilities Act Amendments Act (ADAAA) revised in 2008. Under the ADAAA guidelines a person with a disability is one with a physical, mental, emotional or chronic health impairment that ***substantially limits*** one or more major life activity such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

- **I verify that the person named in this document has a substantially limiting disorder that meets the aforementioned ADAAA disability criteria: Yes ☐ No ☐**

If yes, please thoroughly complete this form to document the substantial limitations that are linked to this disorder.

1.Description of the visual loss:

2. Please provide visual acuity. Right eye: Left eye:

3. The extent of the disorder is: ☐ Mild ☐ Moderate ☐ Severe

4. Initial Date of condition onset: **5.** Date of last clinical contact:

6. Expected duration of medical disorder or disability noted above is:
- ☐ Permanent/ Chronic
- ☐ Long term: 3-12 months

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7. Assessment Instruments and Results: (Please describe the procedures used to establish the condition):

8. Medications:

Current medications (dosage and side effects):

Long term medication plan:

Current compliance with medical plan:

9. History of hospitalization:

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10. Describe the functional impact of symptoms in the academic setting:

11. Is this student aware of any realistic limitations regarding how the vision loss may impact their academic performance?

12. Suggested accommodations:

13. Additional information:

Clinician Signature: _____Date:_____

Revised 6/2020