MONTGOMERY COLLEGE

# Disability Support Services

# VERIFICATION OF VISUAL DISABILITY

The Office of Disability Support Services (DSS) provides academic services and accommodations for students with diagnosed disabilities. The documentation provided regarding the disability diagnosis must demonstrate a disability covered under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act (ADA) of 1990. The ADA defines a disability as a physical or mental impairment that substantially limits one or more major life activities. In addition, in order for a student to be considered eligible to receive academic accommodations, the documentation must show functional limitations that impact the individual in the academic setting.

DSS requires current and comprehensive documentation in order to determine appropriate services and accommodations. The outline below has been developed to assist the student in working with the treating or diagnosing healthcare professional(s) in obtaining the specific information necessary to evaluate eligibility for academic accommodations.

A. **The healthcare professional(s) conducting the assessment and/or making the diagnosis must be qualified to do so**. These persons are generally trained, certified, or licensed members of an appropriate medical specialty.

B. **All parts of the form must be completed as thoroughly as possible.** Inadequate information, incomplete answers, and/or illegible handwriting will delay the eligibility review process by necessitating follow up contact for clarification.

C. **The healthcare provider should attach any reports which provide additional related information** (e.g. psycho-educational testing, neuropsychological test results, etc.). 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. Otherwise, this form must be completed in order for students to receive services through DSS at Montgomery College. *Please do not provide case notes or rating scales without a narrative that explains the results.*

D. **The healthcare provider, after completing this form must sign it, complete the Healthcare Provider Information section on the last page, and mail or fax it to the address provided in our letterhead.** The information you provide will not become part of the student's educational records, but it will be kept in the student's file at DSS, where it will be held strictly confidential. This form may be released to the student at his/her/their request. In addition to the requested information, please attach any other information you think would be relevant to the student's academic adjustment.

If you have questions regarding this form, please contact DSS. Thank you for your assistance.

## Student’s Information

Student’s Name: ____

Student’s Phone Number: ____

Student’s Date of Birth: ____

Student’s Email: ____

## Diagnostic Information

Diagnosis: ____

Date of Diagnosis: ____

Last Contact with Student: ____

## Additional Questions

Please describe your assessment procedures and evaluation instruments providing both the quantitative and qualitative information about the student’s abilities including visual acuity, the use of corrective lenses, ongoing visual therapy (if appropriate), etc.

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Describe the symptoms that meet the criteria for the diagnosis.

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Describe the progression of this disability, if applicable.

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

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List current medication(s), dosage, frequency, and adverse side effects.

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What recommendations do you have regarding accommodations (e.g. extra time for exams, enlarged print, books on tape or scanned onto disk, etc.)? Please discuss your rationale for each of the suggested accommodations.

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

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## Healthcare Provider Information

Provider signature: ____

Provider name: ____

Date of signature: ____

Title: ____

Provider License or Certification #: ____

Provider Address: ____

Provider Phone Number: ____

Provider Fax Number: ____

*** Adapted from Ohio State University Disability Verification for Visual Impairments

Email this completed form to: dss@montgomerycollege.edu

Fax this completed form to: 240-567-5097

Mail this completed form to: Office of Disability Support Services SV 305, 51 Mannakee St., Rockville, MD 20850