



Academic Affairs • Office of Student Accessibility Services  
118 Beacon Street • Boston, MA 02116  
Phone (617) 670-4429 • Fax 617-670-4466

**Disability Verification Form – Vision Impairment**

Student Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_ Student ID#: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date of First Diagnosis: \_\_\_\_\_

Date of last Clinical Contact: \_\_\_\_\_

Prognosis/Changes: \_\_\_\_\_

What is the functional limitation in the academic setting: \_\_\_\_\_ Mild \_\_\_\_\_ Moderate \_\_\_\_\_ Severe

Describe the symptoms (include duration/frequency) of the disorder, how it impacts the student functioning in an academic setting and what might exacerbate these symptoms.

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What medications have been prescribed and are there any side effects that may impact the student's academics (Students who are taking medications must inform the College's Nurse)

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Recommendations for accommodations given the specific disability (Accessibility Services will consider this to determine services):

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Professional's Name/Title (Print): \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

This form must be submitted along with current diagnostic evaluations completed within the past 6 months.