GTCC
GUILFORD TECHNICAL COMMUNITY COLLEGE

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disAbility Access Services

Documentation of Visual Impairment Verification Form

As the diagnosing professional, please fully complete all sections of this form. Additional reports, information, or narrative can be attached if appropriate.
Please note: All information that you provide may be shared with this student unless clearly marked otherwise. Thank you for your assistance.

I, _____, hereby authorize the release of the following information to disAbility Access Services at Guilford Technical Community College for the purpose of determining my eligibility for services.

_____ _____ _____
Student Signature Date of Birth Date of Request

TO BE COMPLETED BY THE DIAGNOSING PROFESSIONAL

I. Diagnosis

Primary Diagnosis: _____

Date of Diagnosis: _____ Date of Last Evaluation: _____

Secondary Diagnosis: _____

Date of Diagnosis: _____ Date of Last Evaluation: _____

II. Diagnostic Questions

1. Visual Acuity: If the acuity can be measured, complete this box using Snellen acuities or Snellen equivalents or NIL, LP, HM, CF.

Without Glasses	Best Corrected				
	Near	Distant		Near	Distant
R			R		
L			L		

2. Visual Field Test: If any restrictions to visual field exist, pleas describe below:

   _____

   The visual field is restricted to 20 degrees or less: Yes: _____ No: _____

3. Color Vision: Normal: _____ Abnormal: _____

II. Treatment

Date of Last Visit: _____

Glasses Prescribed: Yes: _____ No:_____

Magnification Aids Prescribed: Yes:_____ No:_____

Braille and Audio Required: Yes:_____ No:_____

III. Current Impact

In the space below please provide a summary of how the disability will impact the student in the educational environment (i.e., limitations/restrictions, stratagies for achieving equal access, etc.). Which services, if any, do you recommend? NOTE: This is for informational purposes only. If required, Guilford Technical Community College will determine the appropriate services.

_____

_____

_____

Thank you for your cooperation in this matter. Your prompt attention will allow us to begin providing services as soon as possible. Incomplete or missing information can prevent or delay necessary services. This form must be completed and signed by the qualified professional who performed the evaluation and made the diagnosis.

Professional Credential Documentation (PLEASE ATTACH YOUR BUSINESS CARD TO THE DOCUMENT OR ANOTHER FORM OF IDENTIFICATION FOR THE STUDENT FILE.)

Name_____

Address_____

Title_____

Professional Credentials_____ Phone : _____

License/Certification number_____

Signature_____ Date_____

To expedite the process, you may fax a copy to (336) 819-2030. All documentation is confidential (in addition to faxing) please mail the signed, original form to:Guilford Technical Community College:
disAbility Access Services
P.O. Box 309
Jamestown, NC 27282

Attention: _____

disAbility Access Services

Creating Successful Futures