University of Windsor

Student Accessibility Services
401 Sunset Avenue, Room 117 Dillon Hall
Windsor, Ontario, Canada N9B 3P4
T 519-253-3000 (3288) F 519-973-7095
www.uwindsor.ca/studentaccessibility

DOCUMENTATION OF VISUAL IMPAIRMENT

Student Name: _____Date of Birth: _____/_____/_____(Year, Month, Day)

SUMMARY:

A. The following is to be completed by an **Ophthalmologist, Optometrist, Low Vision Specialist, Treating Family Physician (who has treated the patient for 6 months or longer and has understanding of the level and functional limitations of the disability) or other qualified professional (please specify on page 3).** All sections of the form must be completed carefully and objectively in order to ensure accurate assessment of the student's disability-related needs. Information contained in this form will be used to determine and provide appropriate supports which may include services, bursaries, academic accommodations while in university, and potential benefits after graduation.

B. Careful consideration should be given to the **statement of disability and degree of impairment.**

C. The following criteria must be met for determination of a **permanent disability.**

☐ Functional limitation due to the disability

☐ Functional limitation restricts ability to perform daily activities necessary to participate in post-secondary studies

☐ Functional limitation is expected to be life-long

Is this student a regular patient of yours/ your clinic? ☐ Yes ☐ No

If yes to the above, what was the date of the most recent appointment? _____

Is this student to be monitored by you? ☐ Yes ☐ No

If yes, how often? _____

Specific diagnosis(es): _____ **Age of diagnosis:** _____

Cause of impairment: _____

Visual acuity (best corrected): _____Left eye _____Right eye _____Bilateral

Visual field limitations: _____

Statement of Disability:

_____Not a disability

_____Temporary or recurring visual impairment that may affect academic functioning and require special consideration for a short duration. The anticipated duration being from ___/___/___/ to ___/___/___/

_____Permanent disability that will require assistance for the duration of university (please refer to point C. above)

In an academic setting, do you consider the impairment to be:

Mild _____ Moderate _____Severe_____

1) Describe the **functional limitations** associated with this impairment, and how they impact on activities of daily living **and** in a university environment.

2) List the patient's current medications and how they may impact on activities of daily living, particularly academic performance.

3) Does the patient require specialized devices (e.g. glasses, computers, etc.) in order to participate in post-secondary education? Please specify.

4) Please provide any additional information about the patient's condition that may assist us in determining appropriate accommodations, with specific reference to functional limitations due to the condition.

5) Do you consider your patient to be in stable condition and capable of sustaining normal academic stress?

☐ Yes ☐ No ☐ Not sure

CERTIFICATE OF ATTENDING PROFESSIONAL:

Signature: _____ Date: _____

Name and Title: _____ Registration Number: _____

Address: _____ Office Stamp:

Telephone: _____

Fax: _____

STUDENT'S INFORMED RELEASE:

I, _____, hereby authorize this health practitioner to provide the following information to the University of Windsor, Student Accessibility Services, and, if required, to supply additional information, relating to the provision of my academic accommodations. I also authorize University of Windsor, Student Accessibility Services to contact the physician to discuss the provision of accommodations.

Signature: _____ Date: _____