Services for Students with Disabilities
Verification Form for Students with Blindness and Low Vision

This form is intended to assist in meeting our documentation requirements for these disabilities. However, if not thoroughly completed, it may not be sufficient as the sole form of documentation provided. Please refer to the “Guidelines for Documenting Blindness or Low Vision” for comprehensive documentation requirements and additional information. To ensure the provision of reasonable and appropriate accommodations, students requesting services must provide current (within the last 3 years) documentation of the disability. This documentation should provide information regarding the onset, longevity and severity of symptoms, as well as the specifics describing how it has interfered with educational achievement. Please include a copy (including test scores) of any relevant psychoeducational or neuropsychological reports. To standardize our gathering of information, it is recommended that you complete the following questions, even if the material has already been included in your full evaluation. All information will be kept confidential. Please feel free to contact SDS at (919) 530-6325 with questions.

The information below is to be completed and signed by the student.
I request and authorize North Carolina Central University, Office of Student Disability Services and/or my off-campus provider

(name) ______________________________________________________________________ to release, fax, mail or discuss with each other information related to my registering with Student Disability Services (SDS).

__________________________________________________________
Student Name

__________________________________________________________
Student Signature

__________________________________________________________
Email Address:

__________________________________________________________
Date

__________________________________________________________
Phone Number:

If the information above is left blank or is incomplete it may delay or prevent SSD from contacting the student to verify receipt of the documentation and provide next steps for completing the registration process.
The information below is to be completed and signed by the Provider.

1. Please list all diagnoses and supporting numerical assessment of vision:

Diagnoses:

_______________________________________________________________________________________

________________________________________________________________________________________

Visual Acuity with Correction:_______________________________________________________________

Visual Acuity without Correction:_____________________________________________________________________

a. Date diagnosed: __________ / __________ / _________

b. Date of your last clinical contact with student: __________ / __________ / _________

2. Evaluation

a. How did you arrive at this diagnosis? Please check all relevant items below, adding brief notes that you think might be helpful to us as we determine eligibility for accommodations.

   o Structured or unstructured interviews with student.
   o Interviews with other persons (i.e. parent, teacher, therapist).
   o Behavioral observations.
   o Neuropsychological testing. Attach documentation.
   o Psychoeducational testing. Attach documentation.
   o Other (Please specify). _____________________________________________________________________

b. Current treatment being received by student:

   o Medication management:
     Current medications: _______________________________________________________________________

   o Outpatient therapy:
     Frequency:
   o Group therapy: __________________________________________________________________________
     Frequency:
   o Other (please describe): __________________________________________________________________
c. Approximate onset of diagnosis:
   - Child- approximate age: __________
   - Adolescent- approximate age: __________
   - Adult- approximate age: __________
   - Unknown

Severity of symptoms
   - Mild
   - Moderate
   - Severe

Prognosis of disorder:
   - good
   - fair
   - poor

Please explain: __________________________________________
________________________________________________________________

3. **Functional Limitations:** Should be determined WITHOUT consideration of mitigating measures (i.e. medication, etc.). If condition is episodic in nature, level of functioning should be assessed based on active phase of symptoms.

   a. Does this condition significantly **limit one or more of the following major life activities**?

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<th></th>
<th>No Impact</th>
<th>Moderate Impact</th>
<th>Substantial Impact</th>
<th>Don't Know</th>
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<tbody>
<tr>
<td>Communicating</td>
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<td>Concentrating</td>
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<td>Hearing</td>
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<td>Learning</td>
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<td>Manual Tasks</td>
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<td>Reading</td>
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<td>Other:</td>
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b. Please check the **functional limitations or behavioral manifestations** for this student:

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<th>Moderate Issue</th>
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<td>Cognitive Processing</td>
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<td>Memory</td>
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<td>Processing Speed</td>
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<tr>
<td>Meeting Deadlines</td>
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<td>Attending class</td>
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<td>Organization</td>
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<td>Reasoning</td>
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<td>Stress</td>
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c. Please describe in detail any functional limitations that fall into the substantial range.

____________________________________________________________________________________

____________________________________________________________________________________

d. Special considerations, e.g. medication side effects:

____________________________________________________________________________________

____________________________________________________________________________________

e. **COURSE LOAD REDUCTION**: Is the student’s condition such that it may require them to drop a course and/or take fewer than what is considered a full-time course load?

  o Yes
  o No
  o I don’t know

____________________________________________________________________________________

If YES please explain:_________________________________________________________________
4. Accommodations

a. Please mark whether student has utilized accommodations in the past.
   - Yes - Please describe: _____________________________________________
   - No
   - Don't Know
b. (Optional) Recommended educational accommodations:
   ________________________________________________________________
   ________________________________________________________________
c. (Optional) Please provide any additional information you feel will be useful in determining the nature and severity of the student’s disability, and any additional recommendations that may assist in determining appropriate accommodations and interventions:
   ________________________________________________________________
   ________________________________________________________________

Thank you for your help in providing this information so that we may begin services as soon as possible. Please complete the provider information below. This form should be signed and returned via fax or mail to the SDS office at the address shown at the end of this document. All documentation submitted to SDS is considered confidential.

<table>
<thead>
<tr>
<th>Provider Information</th>
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<tbody>
<tr>
<td>I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above.</td>
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<tr>
<td>Signature: __________________________ Date: __________________________</td>
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<tr>
<td>Print Name and Title: __________________________</td>
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<td>State of License: __________________________ License Number: __________________________</td>
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<td>Address __________________________</td>
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<tr>
<td>Street or P.O. Box __________________________ City __________________________ State __________________________ Zip</td>
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<tr>
<td>Phone: __________________________ Fax: __________________________</td>
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</tbody>
</table>

All documentation is confidential and should be submitted to:

North Carolina Central University
1801 Fayetteville Street
Suite 120 Student Services Building
Durham, NC 27707
Attention: Director of Student Disability Services
Fax: 919-530-6938