

**Lake Michigan College Student Outreach and Support Services
Serving Benton Harbor, South Haven, and Niles Campuses
2755 E. Napier Ave Benton Harbor, MI 49022
Phone: (269) 927-8866 Fax: (269) 927-6536**

**DISABILITY DOCUMENTATION FORM:
BLINDNESS AND VISUAL IMPAIRMENT**

PLEASE REVIEW CAREFULLY

The individual named below has applied for services from the Student Outreach and Support Services (SOSS) at Lake Michigan College. Lake Michigan College provides academic accommodations to individuals with disabilities. Individuals seeking services must provide appropriate medical documentation of their condition so that the SOSS can: a) determine eligibility for accommodations, and b) if eligible, determine appropriate accommodations.

The Americans with Disabilities Act (ADA) defines disability as “a physical or mental impairment that substantially limits one or more major life activities, a record of such impairment, or being regarded as having such an impairment.” Disabilities involve substantial limitations and are distinct from common conditions not substantially limiting major life activities.

Documentation required to verify the condition, severity, and functional limitations includes completion of this form or provision of equivalent information on official letterhead to the SOSS by a medical professional with appropriate training and credentials (Neuro-ophthalmologist, Ophthalmologist, Low Vision Specialist, etc.). Professionals completing this form must have first-hand knowledge of visual impairment, experience in working with the individual’s visual impairment, and ideally a familiarity with the physical, emotional and cognitive demands experienced by students in an academic setting. Diagnoses and documentation of visual impairment by relatives are unacceptable.

LMC SOSS Disability Documentation: Visual Impairment

Client Name: Last, First, Middle Initial _____

Date of Birth: _____ LMC Student ID (eight digits): _____

Certifying Professional's Printed Name: _____

Credentials/Specialization: _____

License Type: _____

License #: _____ State: _____ Exp. Date: _____

Mailing Address: _____

City/State/Zip: _____

Phone: (____) _____ Fax: (____) _____

Email: _____

Attach Business Card Here
or
If Submitting Electronically,
Denote your Office Web Address

Office web address _____

Diagnosis/Diagnoses: _____

Date of onset: _____ Date of diagnosis: _____

Visual Acuity (with best correction):

Distance: OD OS OU

Near: OD OS OU

Visual Field: OD OS OU

Other comments about the diagnosis: (e.g. night vision, depth perception, ocular mobility/balance, color perception, etc.)
: _____

Prognosis (expected duration, stability, or progression of the condition, etc.)
: _____

Treatments, medications, devices, or services currently prescribed or used to address the diagnosis/diagnoses above (e.g. monocular telescope, low-vision devices, long cane, CCTV, use of dog guide, etc.)
: _____

From your perspective, describe possible accommodations that could facilitate academic performance
: _____

Additional comments
: _____

Using the contact information on page one, print, sign below, and fax/send directly to the Student Outreach and Support Services.

Date:

Certifying Professional's Signature:

Signature denotes: content accuracy, adherence to professional standards and guidelines on page 1 of this document.