



**Disability Disclosure Form – Vision Impairment**

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

Dear (Clinician Name) \_\_\_\_\_ :

I am requesting services from the Disability Resource Center (DRC) at Northeastern University. In order to receive services, the DRC requires documentation of my disability. Services at the DRC are solely based on diagnostic documentation. Once this information is in place, it will be used to develop a service plan for me.

- I hereby authorize you to complete the enclosed Disclosure Form and release it to the DRC.
- I authorize you to attach a copy of my current vision report, as requested.
- I also authorize you to speak with my DRC Specialist in consultation to provide future services.

**Please submit the completed form to:**

**Ms. Debbi Auerbach, Service Coordinator**

**By mail:**

Northeastern University  
Disability Resource Center  
20 Dodge Hall  
360 Huntington Avenue  
Boston, MA 02115

**By confidential fax: 617-373-7800**

You may contact Ms. Auerbach with any questions (phone: 617-373-2675 / TTY: 617-373-2730 or email: d.auerbach@neu.edu).

Thank you for your timely assistance with this matter.

Sincerely,

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Medical Record ID#



## Disability Disclosure Form – Vision Impairment

This form must be completed by the licensed clinician or health care provider **who is treating this patient for the diagnosis identified** in this document. **Also, please attach the most recent vision evaluation.**

**Patient’s/Client’s Name:** \_\_\_\_\_

**Clinician’s Name:** \_\_\_\_\_

**Clinician’s State Licensure/ Certification #:** \_\_\_\_\_

**Area of Specialty:** \_\_\_\_\_ **Clinician’s phone #:** \_\_\_\_\_

The person named on this form is requesting services from the Disability Resource Center. The DRC offers services to students who are considered disabled under the mandates of the Americans with Disabilities Act As Amended of 2008 (ADAAA). Under the ADAAA definition, a person with a disability is one with a physical, mental, emotional or chronic health impairment that substantially limits one or more major life activity such as caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. Major life activities also include bodily functions relating to the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproduction (*this is not an exhaustive list*).

***I verify that the person named in this document has a substantially limiting disorder that meets the aforementioned ADAAA disability criteria:    Yes     No***

If **yes**, please thoroughly complete this form to document the substantial limitations that are linked to this disability.

▪ **Diagnosis/Description of Disability:** \_\_\_\_\_

▪ **Please provide full DSM or ICD-9 code:** \_\_\_\_\_

▪ **Initial Date of Diagnosis:** \_\_\_\_\_      ▪ **Date of last clinical contact:** \_\_\_\_\_

- **Expected duration of disability noted above is:**
  - Permanent
  - Chronic
  - Long term (3-12 months)
  - Short term (60-90 days)
  - Temporary (1-60 days)

\*Website: [www.northeastern.edu/drc](http://www.northeastern.edu/drc) \* Phone: (617) 373 2675 V, (617) 373 2730 TTY \* Fax: (617) 373 7800\*





▪ Please comment on the following items as applicable:

- **Visual acuity:** Right Eye \_\_\_\_\_ Left Eye \_\_\_\_\_
- **Preferred Lighting** (*natural, fluorescent, incandescent, etc.*): \_\_\_\_\_
- **Night vision:** \_\_\_\_\_

▪ **Rate Mobility and Orientation** (*travel skills*):    **Novice**                      **Intermediate**                      **Advanced**

▪ **Areas needing improvement:** \_\_\_\_\_  
\_\_\_\_\_

▪ **This person uses any or all of the following** (*check specific device or service*):

- |   |  |
|---|--|
| <input type="checkbox"/> Access to print materials ( <i>circle all that apply</i> ):<br>Audio    Braille    Large Print | <input type="checkbox"/> Long White or Collapsible Cane                                    |
| <input type="checkbox"/> Assistive technology/software ( <i>please specify</i> ):<br>_____                              | <input type="checkbox"/> Other technology for mobility ( <i>please specify</i> ):<br>_____ |
| <input type="checkbox"/> Guide dog<br>Training center if known:<br>_____  | <input type="checkbox"/> Other ( <i>please specify</i> ): _____                            |
|   | <input type="checkbox"/> Public transportation or Paratransit                              |

▪ **Suggested Accommodation(s) for the academic setting:**

- |   |  |
|---|--|
| <input type="checkbox"/> Access to Online Information | <input type="checkbox"/> Note-taking/Recorded lectures             |
| <input type="checkbox"/> Access to Print Materials    | <input type="checkbox"/> Other ( <i>please specify</i> ):<br>_____ |
| <input type="checkbox"/> Lab or Classroom Aide        |  |

▪ **Additional information:**

Clinician/Professional Signature

Date

**NOTE: Please attach a current Vision Report to this Disclosure Form**