



Documentation Guidelines Low Vision / Blind

Students requesting support services through the **ACCESS Office** at Collin College are required to submit documentation, **after admission to Collin College**, to verify eligibility under the Americans with Disabilities Act of 1990, ADA Amendments Act of 2008, and Section 504 of the Rehabilitation Act of 1973. Academic accommodations by the **ACCESS Office** are there to ensure **equal access** to educational activities and programs at Collin College.

Current documentation must validate the need for services based on an **individual's present level of functioning**. In order for a person to qualify under the Americans with Disabilities Act, ADA Amendments Act of 2008, or Section 504 of the Rehabilitation Act, **a disability must substantially limit a major life function (learning)**. Therefore, a well-written report with an interpretive summary based on a comprehensive evaluation is a necessary component of documentation. **ACCESS** will determine if reasonable and appropriate academic accommodations are warranted and can be provided for an individual.

Students may have one or more physical conditions for which they are being treated, and these may be temporary, chronic, or progressive in nature. Students requesting support services through **ACCESS** are required to submit current documentation of their disability, which must affect a major life function in order to qualify for services.

These guidelines will assist you in working with your medical professional to prepare information needed for **ACCESS** to determine your eligibility for requested academic accommodations. The documentation must include the following:

1. An evaluation and diagnosis made by an Ophthalmologist or Optometrist. Provide the evaluator's name, title, and professional credentials and affiliations. Include information about licensure, area of specialization, and the professional address and phone number of the physician. **The evaluator must be impartial and not related to the person being evaluated.**
2. Documentation from the attending physician must be typed on letterhead
3. The documentation must include:
 - Specific medical diagnosis for the disabling condition(s) with supporting numerical description. (e.g., 20/200, visual field less than 20 degrees)
 - Visual Acuity
 - Brief medical history related to the diagnosis (including age of onset)



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- Indication of the status of the disability:
 - Is the disability stable, chronic, progressive, fluctuating?
 - Is the disability temporary or permanent?
 - Statement regarding severity of the disability (mild, moderate, severe)
 - List of current functional limitations for the individual in an educational setting
 - Recommendations for academic accommodations based on specific conditions/symptoms of the disability (e.g., adaptive technology/equipment, Braille, enlarged font, specific lighting)
4. The diagnosis must be current. However, the age of the documentation is dependent on the nature/stability of the disability. It should accurately reflect how the disability currently impacts the student in a college setting
 5. Documentation must reflect the **functional limitations** and current symptoms/conditions. If the documentation does not, students may be required to submit updated information and/or documentation
 6. Medical professional may complete **Documentation Guidelines for Low Vision/Blind form** to assist in providing information requested above. ***This form can be used to accompany or supplement medical reports. Please type or print.***

Documentation received will be reviewed by a committee, and the student will be notified of the decision regarding eligibility. Documentation is reviewed weekly; however, during peak times, we request at least two to three weeks to notify student of the decision regarding eligibility. Providing documentation does not automatically qualify an individual for academic accommodations.



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I, _____, request that _____ complete and submit the document below to Collin College's ACCESS Office to assist them in determining my eligibility for academic accommodations. I consent to the release of this information and other pertinent medical evaluations/records to Collin College. I understand that I can revoke this Consent by giving written notice of revocation.

Student Name (print) Student Signature Date DOB

If under 18 years of age, a parent must also sign this request. Parent Signature Date

Dear Medical Professional,
The above mentioned student has applied for academic accommodations with Collin College. In order to determine if this student will qualify, we need your medical / clinical assessment of this student. We are requesting the necessary information to determine if this student's medical condition substantially limits one or more major life activities, including learning. PLEASE TYPE OR PRINT.

- 1) Please list student's diagnoses and medical condition with ICD 10 diagnostic code.
2) Date of initial diagnosis:
3) Is the patient currently under your care? Yes / No Date last seen:
4) List of medication(s) and/or treatment student is receiving for this condition:
5) List patient's current level of visual acuity:
6) Please list any possible side effect(s) of the medications or treatment that might impact the student in an educational setting.
7) Medical condition is: acute / permanent
If acute, anticipated date of full recovery:
8) Medical condition is: stable / progressive



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Student: _____ Primary Diagnosis: _____

Please list current functional limitations as they relate to an educational setting ((i.e. – unable to read blackboard / white board, unable to read below 14 pt font, unable to see textbook or materials without direct overhead light, etc.)

Please list recommendations for academic accommodations based on functional limitations you listed above:

***Please attach copy of visual acuity exam and other visual evaluations that would assist us in determining appropriate academic accommodations for this student.

Note: Evaluator must be impartial and not related to the person being evaluated.

Certifying Medical Professional:

Date

Medical Professional's Title

Medical Professional's Name (print)

Medical Professional's Signature

Mailing Address

Phone

City, State, Zip

Fax

Please mail or fax completed form with supporting documents to address below: