



JOLIET JUNIOR COLLEGE

1901

1215 Houbolt Road • Joliet, IL 60431

DISABILITY SERVICES

(815) 280-2230 or (815) 280-2941 • Office A-1125

BLIND/LOW VISION DOCUMENTATION

Date: _____ Date of Birth: _____

Name of Student: _____

Dear Medical Professional:

The student whose name appears above has applied for services from the Disability Services Office at Joliet Junior College. To provide disability-related services, we need to establish this student has a disability. A disability is defined as impairment substantially limiting a major life activity. Please assist the student by completing the information below. If you prefer, you can answer these questions in a signed and dated letter on your professional letterhead.

Impairment Assessment

1. What is his/her visual acuity? _____

Without correction _____

With correction _____

2. Does he/she have a visual field loss? If so, please describe.

3. Does he/she need bifocal lenses? Please describe and explain.

4. Is there a discrepancy between his/her distance and near vision?

5. Does he/she have an eye muscle imbalance? If so, please describe.

6. Would he/she benefit from the use of magnifiers?

7. What is the strength (in diopters) of his/her lenses?

8. Does he/she wear corrective lenses (eyeglasses and/or contact lenses)?

9. What is the diagnosis/impairment?

10. Date of the original diagnosis:

11. Is the impairment temporary (<6 months) or persistent?

Signature of Professional

Date

Health Professional's Name (printed) and Title

License Number

Clinic Name and Street Address

Telephone Number

City, State, Zip Code

Fax Number