In order for us to provide disability-related services, we need to establish that this individual has a physical, sensory or mental impairment that limits one or more of the major life activities. This form is designed to help us make that determination.

**PLEASE PROVIDE THE FOLLOWING INFORMATION IN FULL**

Patient/Student Name: ___________________________________  Date: ____________________

Last   First   M.I.

Note: Please attach a copy of any supportive report or test results you believe would be helpful to us in determining eligibility and appropriate services.

1. Date of last appointment with this individual:

2. Please describe this individual's visual impairment:

   Vision loss is:  □ mild  □ moderate  □ severe

3. Specify visual acuity with best correction:

4. Is this impairment permanent or temporary? If temporary, what is the expected duration?

5. Quality of Life: In general, this individual's quality of life is:
   □ Excellent  □ Good  □ Fair  □ Poor  □ Very Poor

- Continued on Page 2 -
6. Please specify functional limitations related to the impairment (i.e., length of time able to sustain reading and/or writing; size of print needed; how long activity can be performed before needing a break; length of breaks between activities).

7. **Functional Limitations**: Please check the level of limitation you believe this individual experiences in the college environment as a result of his or her disability. Check only those boxes that apply.

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<th></th>
<th>1 = Unable to determine</th>
<th>2 = Mild</th>
<th>3 = Severe</th>
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<tbody>
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<td>Caring for Oneself</td>
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<td>Talking</td>
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<td>Hearing</td>
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<td>Walking/Standing</td>
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<td>Interacting with Others</td>
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<td>Sleeping</td>
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</tbody>
</table>

8. **Additional Comments**:

**Note**: Qualified diagnosing professionals are licensed optometrists and ophthalmologists and, in some instances, other licensed physicians. The diagnosing professional must have expertise in the diagnosis of the documented disability, follow established best-practices in the field, and not be related to the patient.

Print Name: ___________________________________________  License Number: ________________________

Signature: ____________________________________________

Address: _____________________________________________

Phone ___________  Fax ________________  Email __________________

__________________________
Return To: Disability Resource Center - Bldg. 124-119
California Polytechnic State University - San Luis Obispo, CA 93407-0205
Phone: 805-756-1395 FAX: 805-756-5451