Revised 11/2018

JOLIET JUNIOR COLLEGE
1901

1215 Houbolt Road ▪ Joliet, IL 60431

DISABILITY SERVICES

815-280-2230 or 815-280-2941 ▪ Fax 815-280-2820 ▪ 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