





Disability Resource Center  
20 Dodge Hall  
Boston, MA 02115  
617 373-2675 (Voice)  
617-373-2730 (TTY)  
617-373-7800 (Fax)

Date:

Dear

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 and 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 Blind or Legally Blind Disclosure Form and release it to the DRC. 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. Should you need to contact Ms. Auerbach you may reach her at 617-373-4428 (voice), 617-373-2730 (TTY) or you may email her at D.Auerbach@neu.edu.

Thank you for your assistance in this matter.

Sincerely,

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

\_\_\_\_\_  
Date

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

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

Disability Resource Center  
20 Dodge Hall  
Northeastern University  
Boston, Massachusetts 02115-5096  
Phone: 617-373-2675  
Fax: 617-373-7800  
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## Blind or Legally Blind Disclosure Form

For Office Use Only

Date Received:

The licensed clinician or health care provider **who is treating this patient for the diagnosis identified** in this document **must** complete this form.

### **INCOMPLETE FORMS WILL DELAY POTENTIAL SERVICES**

Student's Name: \_\_\_\_\_

Clinician's Name: \_\_\_\_\_

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 of 1990 (ADA). Under the ADA guidelines 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, walking, seeing, hearing, speaking, breathing, learning, and working.

- **I verify that the person named in this document has a substantially limiting visual loss that meets the aforementioned ADA disability criteria: Yes  No**

If yes, please complete all numbered areas on this form; please document the substantial limitations that are linked to this disorder. Incomplete forms will delay potential services for this individual.

#### **1. Diagnosis/Description of the visual loss:**

**2. Please provide visual acuity. Right eye: Left eye:**

**3. The extent of the disorder is:**  Mild  Moderate  Severe

**4. Initial Date of Diagnosis:**

**5. Date of last clinical contact:**

**6. Expected duration of medical disorder or disability noted above is:**

- Permanent/ Chronic
- Long term: 3-12 months

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**7. Assessment Instruments and Results:** (Please describe the procedures used to establish the diagnosis):

**8. Medications:**

Current medications (dosage and side effects):

Long term medication plan:

Current compliance with medical plan:

**9. History of Hospitalization:**

**10. Does this person create a threat to themselves or others (explain)?**

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**11.** Describe the Functional Impact of Symptoms in the Academic Setting:

**12.** Is this student aware of any realistic limitations regarding how the visual loss may impact their academic performance?

**13.** Suggested Accommodations:

**14.** Additional information:

Clinician Signature: \_\_\_\_\_ Date: \_\_\_\_\_