

FORM F VISUAL DISABILITY VERIFICATION

NOTICE TO APPLICANT: This section of this form is to be completed by you. The remainder of the form is to be completed by the qualified professional who is recommending testing accommodations for you on the basis of a visual disability. Please read, complete, and sign below before submitting this form to the qualified professional for completion of the remainder of this form.

Student's full name: _____

Student Number: _____

I give permission to the qualified professional completing this form to release the information requested on the form, and I request the release of any additional information regarding my disability or accommodations previously granted that may be requested by Taft Law School.

Signature of Student

Date

NOTICE TO QUALIFIED PROFESSIONAL:

The above-named person is requesting accommodations. All such requests must be supported by a comprehensive diagnostic evaluation by the qualified professional who conducted an individualized assessment of the student and is recommending accommodations on the basis of a visual disability. Taft Law School requires the qualified professional to complete all questions on this form that pertain to the student's visual impairment. Reference specific tests or other objective data and clinical observations, and **attach copies of test results**, if relevant. Your assistance is appreciated.

Taft Law School may forward this information to one or more qualified professionals for an independent review of the student's request. Print or type your responses to the items below. **Return this completed form, the comprehensive evaluation report, and relevant records to the student for submission to the Taft Law School.**

I. Evaluator/Treating professional information

Name of professional completing this form: _____

Address: _____

Telephone: _____ Fax: _____

E-mail: _____

Occupation and specialty: _____

License number/Certification/State: _____

Describe your qualifications and experience to diagnose and/ or verify the student's condition or impairment and to recommend accommodations.

II. Diagnosis

1. What is the student's current diagnosis? Include a statement as to whether the condition is stable or progressive.

2. Please state the student's best corrected visual acuities for distance and near vision.

3. When was the student's visual disability first diagnosed? _____

4. Did you make the initial diagnosis? ☐ Yes ☐ No

5. Provide the date of your last complete evaluation of the student. _____

6. Is this a permanent condition/impairment? ☐ Yes ☐ No

If no, when is it likely to abate?

7. Does the severity of the condition/impairment fluctuate? ☐ Yes ☐ No

If yes, describe the settings and/or circumstances affecting severity that are relevant.

III. Diagnosis-Specific Findings. Only Address Relevant Areas.

1. Please describe the student's eye health (both external and internal evaluations).

2. Visual Field: threshold field, not confrontation (provide measurements and copies of reports)

3. Binocular Evaluation: eye deviation (provide measurements), diplopia, suppression, depth perception, convergence, etc. Specify whether difficulty with distance, near point, or both.

4. Accommodative Skills: at near point, with and without lenses (provide measurements)

5. Oculomotor Skills: saccades, pursuits, tracking

IV. FUNCTIONAL LIMITATIONS

1. Describe the functional impact, if any, of the student's visual condition on the student's reading ability.

2. Describe the student's current functional limitations and explain how the limitations restrict the condition, manner, or duration under which the student can take examinations.

3. Briefly describe any treatment, including any prescribed medications, and the effectiveness of treatment in reducing or ameliorating the student's functional limitations.

V. ACCOMMODATIONS RECOMMENDED

Taking into consideration the functional limitations currently experienced by the student, what accommodation do you recommend?

Alternative Formats

- ☐ Audio CD version of the Examination
- ☐ Large Print Examination Materials
(check one: ☐ 18 pt or ☐ 24 pt.)
- ☐ Computer with SofTest installed
- ☐ Private Room
- ☐ Semi-private Room
- ☐ Microsoft Word document on data CD
for use with screen-reading software (for
written sessions)
- ☐ Other _____

Personal Assistance

- ☐ Dictate to a Typist
- ☐ Reader
- ☐ Assistance with multiple-choice
answer sheet (Scantron sheet)
- ☐ Dictate to a Tape Recorder

Please provide rationale for requests indicated:

Accommodation of Extra Time

Specify the amount of **additional time** requested for each session of the examination. Indicate why additional specified time is needed (based on the diagnostic evaluation) and the rationale for recommending the amount of time for each test format of the examination. **All requests for additional time must specify the exact amount of additional time. It is important to keep in mind that breaks are included in the timed portion of the examination. No accommodation of unlimited time will be granted. If additional testing time is requested, but the specific amount of additional time is not indicated, the petition will be returned as incomplete.**

Essay: Specify the amount of additional test time needed per session and rationale:

Performance Test: Specify the amount of additional test time needed per session and rationale:

Multiple-Choice: Specify the amount of additional test time needed per session and rationale:

V. PRIOR HISTORY AND PAST ACCOMMODATIONS

Please describe any previously documented history of learning disabilities and list accommodations that have been granted to the student in the past:

VI. CONFIDENTIALITY

Confidentiality policies of Taft Law School will be followed regarding its responsibility to maintain confidentiality of this form. No part of the form or the diagnostic report will be released without the student's written consent or under the compulsion of legal process.

VII. CLINICIAN/LICENSED PROFESSIONAL'S SIGNATURE

I attach hereto copies of all test results, evaluations, educational or psychological reports that I relied upon in making this diagnosis of the student's condition/disability (notes and worksheets are not required as part of this submission). **This is required.**

I declare under penalty of perjury under the laws of the State of California that the above information is true and correct.

(Signature of Clinician/Licensed Professional)

(Date)

Taft Law School reserves the right to make final judgment concerning testing accommodations and may have all documentation related to this matter reviewed by a panel or professional consultants if deemed necessary.