

**CONFIRMATION OF VISUAL DISABILITY  
For the California State University Foundation**

A **disability** shall mean a physical or mental impairment of an individual that limits one or more of the major life activities and requires either a record of such an impairment, or documentation of having been regarded as having such an impairment.

**Visual limitation:** Blindness or partial sight to the degree that it impedes the educational process and necessitates accommodations, support services, or programs.

**Consumer/Client/Patient:**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Best Corrected vision: OD (right eye) \_\_\_\_\_ OS (left eye) \_\_\_\_\_

OU (both eyes) \_\_\_\_\_

Visual Field (in degrees): \_\_\_\_\_

Specific eye condition(s):

**Certifying Authority:**

I certify that \_\_\_\_\_ has a visual disability as specified above.

(Signed) \_\_\_\_\_ (Date) \_\_\_\_\_

(Title) \_\_\_\_\_

**Print/type your name, profession, and address here:**