Verification of Visual Impairment (Supplementary Information Request)

NOTE: Forms completed or altered by anyone other than the Certifying Medical Professional whose signature appears on this form will not be processed.

Patient Information	
Legal Name:	Date of Birth (MM/DD/YYYY):

1. **Please check one:** I certify that I am an ☐ **Ophthalmologist**, ☐ **Optometrist**, or an ☐ **Orthoptist** with expertise in diagnosing and/or treating the condition(s) indicated below.

2. Indicate your **formal diagnosis**:

Formal Diagnosis	**Date of Onset**	**Expected to Persist ☑**
		☐ Less than 2 years ☐ 2+ years ☐ Not expected to improve

3. I certify the Applicant is visually impaired according to the following criteria (check **all** that apply):

☐ A visual acuity of 6/21 (20/70) or less **in the better eye after correction**.

☐ A visual field of 20 degrees or less **in the better eye after correction**.

☐ Any progressive eye disease with a prognosis of becoming one of the above in the next two years.

☐ An **uncorrectable** vision problem or reduced visual stamina such that the client functions throughout the day as if his/her visual acuity is limited to 6/21 in the better eye **after correction**.

4. Is there **anything else** you think we should know about the Applicant's medical condition (including recommendations for support)?

Certifying Medical Professional

*I certify that the information provided on this form is **accurate and current** to my knowledge and that the person identified in this assessment as "the Applicant" **experiences the impairments** I have indicated.*

Name of Certifying Medical Assessor:		Registration/Certificate#:
Specialty/Occupation of Medical Assessor:		Telephone Number:
Mailing Address:		Fax Number:
City/Town:	Province:	Postal Code:
Signature (in ink):		Date: