

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):

- 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.
- Indicate your **formal diagnosis**:

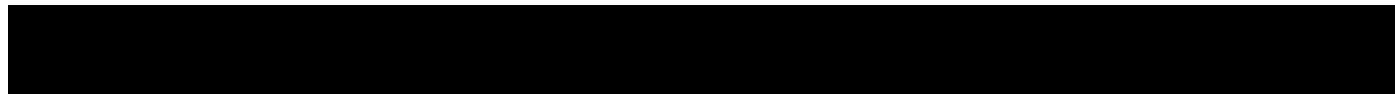
Formal Diagnosis	Date of Onset	Expected to Persist <input checked="" type="checkbox"/>
		<input type="checkbox"/> Less than 2 years <input type="checkbox"/> 2+ years <input type="checkbox"/> Not expected to improve

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

<input type="checkbox"/> A visual acuity of 6/21 (20/70) or less in the better eye after correction. <input type="checkbox"/> A visual field of 20 degrees or less in the better eye after correction. <input type="checkbox"/> Any progressive eye disease with a prognosis of becoming one of the above in the next two years. <input type="checkbox"/> 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.

Professional 4. Is there **anything else** you think we should knowd

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*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: