Visual Capabilities Checklist

Name:

Date of Birth: MM/DD/YYYY

To determine if the above-named individual is capable of working, considering their visual abilities, please provide the following information:

What is the nature of the person's visual impairment?	
Describe any limitations the person is experiencing because of their visual capabilities:	
How do these limitations affect the person and their job performance?	
What specific job tasks are problematic because of these limitations?	
Are there specific environments the person should avoid?	
What accommodation or modification would allow the person to overcome these limitations?	

Is working prohibited due to their visual impairment? ☐ *Yes* ☐ *No*

*If **No**, are there any restrictions to consider?*

What accommodations, supports, or other measures will facilitate the person's success?

(e.g., Employee should work in a well-lit environment with use of a color inspector for work tasks that require identification or sorting of colors.)

Visual Acuity (Use Snellen Notation)				
	Without Glasses		With Best Possible Correction	
	Distance (20 feet)	Near (14 inches)	Distance (20 feet)	Near (14 inches)
Left Eye				
Right Eye				

Health Care Provider's Original Signature

Date

Health Care Provider's Address

Office Phone Number