



Carey M. Wright, Ed.D.  
Interim State Superintendent of Schools

Jody Boone  
Acting Assistant State Superintendent of  
Schools in Rehabilitation

Date: \_\_\_\_\_

To: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Re: \_\_\_\_\_

The above referenced individual has applied for services at the Division of Rehabilitation Services (DORS).

To assist us in making an eligibility determination, please complete the following and return this request to our office.

The above-referenced individual:

☐ is legally blind    ☐ is not legally blind    ☐ is severely visually impaired

Diagnosis: \_\_\_\_\_

ICD-10 Code: \_\_\_\_\_

VF: \_\_\_\_\_

VA: \_\_\_\_\_

A confidential Request for Information, executed by this individual and authorizing you to provide us with information, is enclosed.

THE SIGNATURE OF A LICENSED/CERTIFIED PHYSICIAN IS REQUIRED.

\_\_\_\_\_  
Signature of Licensed/Certified Physician

If you have any questions, please contact: \_\_\_\_\_

Thank you.