

ATTACHMENT C  
**Applicant with Vision Disabilities**

**Name of Applicant:** \_\_\_\_\_

**Name of Licensed Physician:** \_\_\_\_\_

**Date Completed:** \_\_\_\_\_

1. In what capacity do you know the applicant?

\_\_\_\_\_  
\_\_\_\_\_

2. How long have you known or worked with the applicant?

\_\_\_\_\_  
\_\_\_\_\_

3. When did you last see the applicant?

\_\_\_\_\_

4. What is the formal diagnosis of the applicant's eye disease or condition?  
(Please include a visual acuity statement which indicates)  
a) The visual acuity for each eye  
b) The field of vision for each eye  
c) The visual acuity with best correction for each eye)

\_\_\_\_\_  
\_\_\_\_\_

5. What was the date of onset? \_\_\_\_\_

6. What is the prognosis? Is the condition stable, degenerative, or otherwise changing?

\_\_\_\_\_  
\_\_\_\_\_

7. Is the individual able to walk outdoors alone?

- Sometimes                                       Often                                       Never
- 

8.

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If SOMETIMES or OFTEN, where can he/she travel?

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| Only on his/her own property                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| To places nearby (for example, on the same block) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| To places farther away                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If YES to places farther away, please explain.

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9. If the applicant is able to travel outdoors alone, is he/she able to cross streets without help?

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| At quiet streets with very little traffic | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| At traffic lights                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| At very busy intersections                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| NA  | <input type="checkbox"/>     |                             |

Comments: \_\_\_\_\_

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**If the person is partially sighted:**

10. Is he/she able to see steps or curbs?

- Sometimes                       Often                       Never                       NA

Comments: \_\_\_\_\_

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11. Is his/her vision affected by different lighting conditions?

- |                            |                              |                             |
|----------------------------|------------------------------|-----------------------------|
| Bright sunlight            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Dimly lit or shaded places | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Night time                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| NA                         | <input type="checkbox"/>     |                             |

Comments: \_\_\_\_\_  
\_\_\_\_\_

12. Is the applicant's ability to travel outside alone affected by other conditions (consider in particular the impact of environment noise or the inability to distinguish traffic flow patterns)? If so, please describe.

Comments: \_\_\_\_\_  
\_\_\_\_\_

NA

**PLACE LICENSE PHYSICIAN OFFICIAL STAMP BELOW:**

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

Print Name and Title: \_\_\_\_\_

Current Guam Medical License No.: \_\_\_\_\_

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

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

Telephone No.: \_\_\_\_\_ Fax: \_\_\_\_\_