# 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 applicants eye disease or condition?

   Please include a visual acuity statement which indicates

   a. The visual acuity for each eye

   b. The field 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 applicant able to walk outdoors alone?

❑ Sometimes ❑ Often ❑ Never

8. If Sometimes or Often, where can he/she travel?

| | | |
|---|---|---|
| Only on his/her own property | ❑ Yes | ❑ No |
| To places nearby (for example, on the same block) | ❑ Yes | ❑ No |
| To places farther away | ❑ Yes | ❑ No |

If Yes to places farther away, please explain: _____

_____

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

| | | |
|---|---|---|
| At quiet streest with very little traffic | ❑ Yes | ❑ No |
| At traffic lights | ❑ Yes | ❑ No |
| At very busy intersections | ❑ Yes | ❑ No |

Comments: _____

_____

**If the applicant is partially sighted:**

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

❑ Sometimes ❑ Often ❑ Never ❑ N/A

Comments: _____

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

| | | |
|---|---|---|
| Bright sunlight | ❑ Yes | ❑ No |
| Dimly lit or shaded places | ❑ Yes | ❑ No |
| Night time | ❑ Yes | ❑ No |

Comments: _____

12. Is the applicants 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: _____

_____

General Manager

**PLACE LICENSE PHYSICIAN OFFICAL STAMP BELOW**

Signature: _____ Date: _____

Print Name & Title: _____

Current Guam Medical License No. _____

Business Address: _____

_____

Mailing Address: _____

_____

Telephone No: _____ Fax No. _____