An Overview for Applicants:

What Does My Evaluator Need to Do?

Documenting Vision Impairments

A critical part of your request for accommodations is the professional evaluation and report. To facilitate this process, we provide these detailed instructions for you to give to your evaluator. It is also important, however, that you have a general understanding of the evaluation requirements. If you find you have any questions or would like additional information, you can contact us at accommodations@aamc.org.

I. What are the General Requirements of the Evaluator?

In brief, the evaluator must:

a. Be a qualified vision practitioner (i.e., ophthalmologist/optometrist) who has personally examined and evaluated your condition and its impact on your ability to perform on the MCAT under standard conditions.

b. Include his or her name, title, and professional credentials in the documentation, along with a statement regarding formal training and expertise related to the specific vision impairment/condition for which you are seeking accommodations. (This may be in the form of his or her Curriculum Vitae)

II. How Current Must the Evaluation Be?

To document your vision impairment your vision evaluation should have been no more than six months prior to your anticipated MCAT date. Documentation that is between six and 24 months old will be accepted if it is accompanied by a current letter from your eye care professional that provides an update on the diagnosis, current level of functioning, changes since the previous evaluation, current treatment, and continued rationale for the requested accommodations.

III. What Must the Evaluation Report Include?

Although the specifics of the report will vary according to your vision impairment, in general the following components should be included:

1. Identifying Information.
   The first page of the report should be printed on the evaluator’s letterhead, and should include your name, date of birth, date of the evaluation, age at the time of the evaluation, and grade and school (if applicable).
2. **A Comprehensive Evaluation and Clinical Impressions.**
   The report should include a detailed description of a comprehensive vision evaluation, including:
   
   a. Relevant background information, including your academic history and any educational impact from your vision impairment
   b. Discussion of the history of your condition
   c. Discussion of the current treatments for your condition
   d. Discussion of the prognosis for your condition
   e. Actual scores and findings from all tests and procedures administered and all measurements and scales used that collectively demonstrate the level of impairment in visual function must be provided (include test names, results, and age-referenced normal ranges). When relevant to the impairment, examples of such data/findings include: visual acuities (best corrected for near and distance vision), eye health (external and internal evaluations), visual field printouts (formally tested, not confrontation), binocular evaluation (eye deviation, diplopia, suppression, stereopsis), accommodative skills (at reading distances, with and without lenses, provide measurements), oculomotor skills (saccades, pursuits, tracking)
   f. A summary that integrates previous test results, relevant history, current test results, and clinical impressions and includes a diagnostic statement (see below)
   g. Discussion of the functional impact of your vision condition on a major life activity*
   h. Discussion of how your diagnosis and symptoms may impact your ability to take the MCAT exam. When relevant, a detailed description of how your visual condition/impairment affects your reading ability should be provided. It may be appropriate/necessary to include standardized measures of reading rate and processing speed.
   i. Specific recommendations for MCAT accommodations (see below), based on clinical findings
   j. Evaluator's signature

*Major life activities include, among other activities and functions: caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, breathing, learning, reading, communicating and working.

3. **Diagnosis.**
   The diagnosis must:
   
   a. Be based on relevant history, test results, level of current functioning, and clinical judgment, and
   b. Use standard diagnostic codes.

   If you are thought to have two or more disorders, the diagnostic report should clearly describe the **unique impact of each**, and the evaluation guidelines for each disorder should be met.

IV. **What Requirements Must the Evaluator Meet in Making Recommendations?**

The evaluator must provide recommendations that:

1. Are individualized to you,
2. Recommend **specific accommodations and/or assistive devices and,**
3. Describe the rationale for each accommodation (cont.)

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If additional time is requested, the evaluator should specify a **specific amount of additional time along with a rationale for the specified amount of time. Requests for an untimed exam or “extra time” are not sufficient.**
and/or device (i.e., explain how the accommodation(s) will reduce the impact of the identified functional limitations on test taking).

V. Is There Anything Else of Which I should be Aware?

Finally, it will be helpful if you understand two concepts associated with the provision of accommodations. We describe these briefly for you below:

1. **Benchmark.** To be covered under the Americans with Disabilities Act, the “benchmark” is how well you are able to perform compared to *most people* in the general population.

   **Purpose of Accommodations.** Pursuant to 28. C.F.R. § 36.309(b)(1)(i), the purpose of testing accommodations is to ensure, in a reasonable manner, that the “examination results accurately reflect the individual’s aptitude or achievement level or whatever other factor the examination purports to measure, rather than reflecting the individual’s impaired sensory, manual, or speaking skills (except where those skills are the factors the examination purports to measure).”