

Accreditation Reviewer Information Form

Date:

Name:

Preferred Email Address:

Preferred Phone Number (indicate if cell/home/office):

Time Zone:

Job Title:

Employer:

Certifications/Licenses: (Please write in all that apply)

As of the date indicated above, how many years have you worked with or on behalf of individuals who are visually impaired?

Languages in addition to English which you (speak/read/write) fluently:

Please place an X in front of each of the areas below in which you have expertise:

Administration

Human Resources

Finance

Program Evaluation

Independent Living Services

Counseling

Pre-School/Early Intervention

K-12 Programs

(List is continued on next page)

Multiple Disabilities

Low Vision Clinic Services

Vocational Services

Vocational Counseling

Expanded Core Curriculum (after-school/summer)

Industries/Employment Services

Blindness Prevention Services

Provision of Reading Services

Other (please specify)