Accreditation Reviewer Information Form

Name: _____

Preferred Email Address: _____

Preferred Phone Number: _____

State/Province: _____

Job Title: _____

Certifications/Licenses: Please write in all that apply (CATIS, TVI/TSVI, COMS, CVRT, CLVT, OTHER) _____

How many years have you worked with or on behalf of individuals who are visually impaired? _____

Please mark an X for each of your areas of expertise below: _____ __

Administration_____ Human Resources _____ Finance _____

Program Evaluation____ Independent Living Services____

Counseling ____ Pre-School/Early Intervention____ K-12 Programs ____

Low Vision Clinic Services_____ Vocational Services____

Expanded Core Curriculum (after-school/summer)____

Industries/Employment Services____ Blindness Prevention Services_____

Multiple Disabilities _____ Provision of Reading Materials_____

Other (please specify): _____