Case No. _____

Annex "J – Visual Disabilities"

Z BENEFITS FOR CHILDREN WITH VISUAL DISABILITIES

PATIENT (Last name, First name, Middle name, Suffix)	BIRTHDAY (mm/dd/yyyy)
ADDRESS	
CONTACT NUMBER	

CERTIFICATE OF COMPLETED TRAINING AND REHABILITATION SESSIONS

This certifies that patient _____, has completed the following training and rehabilitation for children with visual disabilities as needed:

- ☐ Training on the use of the device
- ☐ Training on activities of daily living
- ☐ Visual skills training
- ☐ Environmental adaptation
- ☐ Others, specify_____

Remarks (if any): _____

_____

Conforme by Patient/Parent/Guardian:

_____
Printed name and signature

Certified by:

_____
Printed name and signature
Attending therapist