APPLICATION FORM

ALL INFORMATION IS KEPT CONFIDENTIAL

XAVIER SOCIETY FOR THE BLIND
248 West 35th Street, Suite 1502
New York, NY 10001-2505
(212) 473-7800 (800) 637-9193
clientservices@xaviersocietyfortheblind.org

PLEASE PRINT

Full Name ____ Date of Birth ___ / ___ / _____

Address ____

City ____________________________ State/Province _____ Zip/ Postal Code ___________

Country ____ U.S. Veteran☐

Primary Phone (Home / Work / Cell) ____

E-Mail _____________________________________@______________________________

How did you hear about us?____

____

PLEASE CHECK OFF ALL BOXES THAT APPLY TO YOU

I am able to read Braille ☐ UEB ☐ I have regular access to the Internet ☐

I have access to electronic scanning of printed material ☐

☐ I am a student (Specify at what level) _________________________________

☐ I live in a group residence (Specify) ___________________________________

For correspondence, which format should be used? Mail ☐ Braille☐ E-Mail ☐

CERTIFICATION

The certification may be supplied by a qualified professional, or by a representative of any institution or agency engaged in working with the visually or physically impaired who has a direct knowledge of the applicant's condition.

Name of Certifier ____

Title (or professional degree) ____

Agency or institution (if applicable) ____

Office Address ____

City____________________________ State/Prov. _______ Zip/Postal_______________

Office Phone ___________________________________

I hereby certify that the following applicant, __________________________________, who is requesting free services of Xavier Society for the Blind, has the following (please check one): Legally Blind ☐ Visual Handicap ☐ Reading Disability ☐ Deaf/Blindness ☐ Physical Handicap ☐ (Please specify_________________) and cannot read standard printed material for the reason indicated above.

Signature of certifier ____________________________________ Date_______________