



**APPLICATION FORM**

**ALL INFORMATION IS KEPT CONFIDENTIAL**

Xavier Society for the Blind  
248 West 35<sup>th</sup> 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 \_\_\_\_\_

Do you attend a Catholic parish on a regular basis? (Please specify) \_\_\_\_\_

Primary Phone (Home / Work / Cell) \_\_\_\_\_

E-Mail \_\_\_\_\_ @ \_\_\_\_\_

Are you a patron of another library for the blind? \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**PLEASE CHECK OFF ALL BOXES THAT APPLY TO YOU**

- I read Braille  I am able to read UEB (Unified English Braille)  I have a braille display
- I have regular access to the Internet
- I have a Talking Book machine from the National Library Service (NLS)

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 \_\_\_\_\_