CLIENT APPLICATION FORM

ALL INFORMATION IS KEPT CONFIDENTIAL

XAVIER SOCIETY FOR THE BLIND
2 Penn Plaza, Suite 1102
New York, NY 10121-1100
(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) ____

Alternate Phone (Home / Work / Cell) ____

E-Mail ________________________________@______________________

PLEASE CHECK ALL BOXES THAT APPLY

☐I am able to read Braille ☐I prefer MP3 Audio

☐I have regular access to the Internet

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

☐ I am currently employed (Specify type of work) __________________________

☐ I am retired (Specify former type of work) ______________________________

☐ 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 from Xavier Society for the Blind, is (please check):

☐(L)Legally Blind ☐(V)Visually Impaired ☐(P)Reading Disabled ☐(D)Deaf/Blind

☐(H)Physically Handicapped (please specify__________________) and cannot read standard printed material.

Signature of certifier ______________________________________ Date_______________