



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) _____

Alternate Phone (Home / Work / Cell) _____

E-Mail _____ @ _____

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 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 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 _____