



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 _____