

# XAVIER SOCIETY FOR THE BLIND – APPLICATION FORM

**\*ALL INFORMATION IS KEPT CONFIDENTIAL\***

Title:	First Name:	M.I.	Last Name:	Suffix:
Address:				
City:		State:	Zip: / Postal Code:	COUNTRY:
Home Phone:	E-Mail:		Date of Birth:	
( ) -			Month: _____ Date: _____ Year: _____	
Work Phone:	Cell:			
( ) -				

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

- I am able to read Braille
  - I have access to electronic scanning of printed material
  - 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) \_\_\_\_\_
- Name of Activity Director/Chaplain/Superior** \_\_\_\_\_ **Phone** \_\_\_\_\_

**If XSB needs to correspond with you, which format should be used?**

*(Please check one type of format)*

- Large Print     Braille     E-Mail

**In which format would you like to receive our annual calendar?**

- Large Print or  Braille;  No, Thank you

**On the enclosed list of ON-GOING PUBLICATIONS is a code-number for each service. In the appropriate column below, please write the code number(s) of the service(s) you desire. Mixing formats is allowed.**

BRAILLE	LARGE PRINT	CD MP3
1. B - _____	1. L - _____	1. D - _____
2. B - _____	2. L - _____	2. D - _____
3. B - _____	3. L - _____	3. D - _____

**PLEASE BE SURE THE OTHER SIDE OF THIS PAGE IS COMPLETED, TOO!**

**XSB Office Use Only:** First correspondence/call received on: \_\_\_\_\_ Application sent by XSB: \_\_\_\_\_  
 Application received by XSB: \_\_\_\_\_ Entered in computer on: \_\_\_\_\_ by: \_\_\_\_\_

**CERTIFICATION FORM**  
**XAVIER SOCIETY FOR THE BLIND**  
154 East 23<sup>rd</sup> Street New York, NY 10010  
Phone: 1-212-473-7800 Toll-Free: 1-800-637-9193  
E-Mail: [clientservices@xaviersocietyfortheblind.org](mailto:clientservices@xaviersocietyfortheblind.org)  
Web-Site: [www.xaviersocietyfortheblind.org](http://www.xaviersocietyfortheblind.org)

This certification, fully completed, must accompany a person's application for the free services of Xavier Society for the Blind. The certification may be supplied by a qualified professional, or by a representative of any institution or agency actively engaged in working with the visually or physically impaired who has a direct knowledge of the applicant's condition.

(Please Print):

Name of **Certifier**: (Last Name) \_\_\_\_\_ (First Name) \_\_\_\_\_

Title (or professional degree): \_\_\_\_\_

Agency or institution (if applicable): \_\_\_\_\_

Office Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Office Phone with Area code ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

I hereby certify that the following **applicant**,

(Print full name of **applicant**): \_\_\_\_\_

who is requesting free services of Xavier Society for the Blind, has the following:

(Please check one):

- Legally Blind
- Visual Handicap
- Physical Handicap (Please specify): \_\_\_\_\_
- Reading Disability:
- Deaf/Blindness

and cannot read standard printed material for the reason indicated above.

Signature of **certifying person**: \_\_\_\_\_

Today's date: \_\_\_\_\_

***Thank you for making certain that ALL requested information is supplied and completed. Please return the Application and Certification Form to Xavier Society for the Blind using the postage-free reply-envelope provided.***