NEW VISION

BRINGING A NEW WORLD TO PEOPLE WITH VISUAL IMPAIRMENTS

# Application for Service

Name: _____ _____ _____
Last First Middle Initial

Institution or Facility (if applicable):

_____

Address: _____
Street (include room or apartment number)

_____
City State Zip

Phone Number *(Required)*:_____
Email Address: _____
Birth Date: _____

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☐Check here if you DO NOT want the Radio Reading Service

☐Check here if you DO NOT want the Dial-In News Service

Upon receipt of your application we will send you the Radio and Listening Instructions and Guides.

Send instructions in: ☐Braille ☐Large Print

*Please Continue on Back of the Page*

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**Certification**

To be completed by a physician, nurse, librarian or social worker. This certification is required for reading services in order to comply with federal law.

*I certify that the above named applicant cannot read or effectively use printed materials as a result of the following condition(s):*

_____

Signature: _____Title: _____

Phone #: _____

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**Signature**

I have signed below, or have **personally requested** this service and authorized this application to be signed on my behalf.

Signature of Applicant: _____ Date: _____

**Secondary Contact Person**

We need contact information of a person not living with you. They will only be contacted if your mail is returned and you have not contacted us with a new address and phone number.

Name: _____ Phone: _____

**Radios remain the property of Voice of the Blue Ridge and the Radio Reading Service and must be returned when no longer in use by the person above.**

Office Use: ID#_____Security #_____Serial #_____Date: _____