



Application for Service

Name: _____
Last First Middle Initial

Institution or Facility (if applicable):

Address: _____
Street (include room or apartment number)

City	State	Zip
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Phone Number (Required): _____

Email Address: _____

Birth Date: _____

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



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 #: _____

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: _____