APPLICATION FOR DEPOSIT ACCOUNT SERVICE

Agency Name: ____________________________________________

Contact Person: __________________________________________

Address: ________________________________________________

City: __________________ County: _______ Zip: ____________

Telephone: __________________ Extension: _________________

E-mail: ________________________________________________

Type of Agency:

☐ Nursing Home  ☐ Hospital  ☐ Other: (Specify)
☐ Adult Day Care  ☐ Books in Braille
☐ Library  ☐ Magazines in Braille

Types of Services Requested – please indicate any/all services your institution wants to receive

☐ Digital books – includes 1 player

☐ Audiovision (Radio Reading Service)

The New Jersey State Library Talking Book & Braille Center is supported by the New Jersey State Library and is funded by the Institute of Museum and Library Services through its Grants to States program.
Adaptive Equipment Requested:

☐ Pillow Speaker – For bedridden readers

Reader Profile:
Check what applies to those who will be using the service.
Books should be in:

☐ English    ☐ Spanish    ☐ Other:__________________________

Restrictions on Book Content:

☐ No explicit descriptions of violence
☐ No explicit descriptions of sex
☐ No strong language

Reading Level(s):

☐ Adult          ☐ Young Adult
☐ Preschool      ☐ Reading Grade Level _________
                      (Indicate)

Subjects:

☐ Adventure  ☐ Mysteries
☐ The Arts    ☐ Nature and Animals
☐ Business & Economics  ☐ Occult and Horror
☐ Cooking     ☐ Poetry
☐ Disabilities ☐ Popular Biography
☐ Entertainment ☐ Religion
☐ Family Stories ☐ Romance
☐ Historical Fiction ☐ Science Fiction & Fantasy
☐ Historical Non-Fiction ☐ Social Issues
☐ Humor       ☐ Sports and Recreation
☐ Literature  ☐ Westerns
☐ Travel      ☐ Minority Experience

Favorite Author(s): ________________________________

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
AUTHORIZATION SIGNATURE
Authorization by facility director or library director is required in order for this application to be processed

As Director of this facility, I certify that this facility regularly provides service to individuals who are unable to read a regular print book because of a permanent or temporary visual or physical disability. I hereby request a Deposit Account with the New Jersey State Library Talking Book & Braille Center in order to provide these individuals with the opportunity to enjoy recorded materials.

Date of Request: ____________________________________________

Signature: __________________________________________________

Printed Name: ________________________________________________

Position Title: ________________________________________________

Mail completed application to:

New Jersey State Library
Talking Book & Braille Center
Attention: Mary Kearns Kaplan
2300 Stuyvesant Avenue
Trenton NJ  08618