

APPLICATION FOR IRIS RADIO

Indiana Reading and Information Services
1630 North Meridian Street
Indianapolis, IN 46202
(317) 614-0404
(877) 854-0077 Toll Free

For Office Use Only

Application Received: _____

Radio #: _____

Applicant Information

IRIS is an Equal Employment Opportunity Company. The information requested herein is used in grant applications to enable us to continue providing this service free of charge to qualified applicants.

PLEASE PRINT

NAME _____
(Last) (First) (Initial) (Mr. / Mrs. / Miss / Ms)

STREET ADDRESS _____ Apt # _____

CITY _____ STATE _____ ZIP _____

PHONE # (_____) _____ DATE OF BIRTH _____
Month/Day/Year

E-MAIL _____

OCCUPATION _____ EMPLOYER _____
RETIRED? YES NO

(Optional)

RACE: CAUCASION AFRICAN-AMERICAN HISPANIC OTHER

HOW DID YOU LEARN ABOUT IRIS? _____

PLEASE LIST TWO (2) INDIVIDUALS WHO WILL BE RESPONSIBLE FOR RETURNING THE RECEIVER IF THE APPLICANT CANNOT DO SO.

NAME _____ RELATIONSHIP _____

PHONE#(_____) _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____

NAME _____ RELATIONSHIP _____

PHONE#(_____) _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____

ELIBIGILITY REQUIREMENTS

Please check the appropriate category:

LEGALLY BLIND

VISUAL IMPAIRMENT

(Inability to read standard printed material without special aids or devices other than regular reading glasses.)

PHYSICAL IMPAIRMENT

(Inability to read or use standard printed material as a result of physical limitations. Specify: _____)

READING DISABILITY

(Organic dysfunction of sufficient severity as to prevent the reading of printed material in a normal manner. **MUST BE CERTIFIED BY A MEDICAL DOCTOR**, fill out Certification of Application section below).

ILLITERACY

ARE YOU ENROLLED IN THE TALKING BOOK PROGRAM? **YES** **NO***

If YES, please sign and return this form to IRIS.

* **If NO**, the certification below must first be completed by a medical or other professional provider. The certifying authority may **NOT** be a relative of the applicant.

APPLICANT'S SIGNATURE _____ **DATE** _____

CERTIFICATION OF APPLICANT

The above-named applicant cannot read or use conventional printed materials as a result of visual/physical limitations.

Certifying Authority & Title: _____

Address: _____

Phone #: (_____) _____

City: _____ State: IN Zip: _____

Signature: _____ Date: _____