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  ☐ Other:

☐ Library

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

☐ Digital books – includes 1 player  ☐ Magazines on Tape

☐ Cassette books – includes 1 player  ☐ Books in Braille

☐ 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
- Key Extenders – For readers with fine motor difficulties

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

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: Dianna La Raia
2300 Stuyvesant Avenue
Trenton NJ 08618