APPLICATION FOR DEPOSIT LIBRARY SERVICE

Library Name:__________________________________________________

Contact Person: ________________________________________________

Address: ______________________________________________________

City: ________________ County:__________ Zip:_______________

Telephone: __________________________Extension:_________________

E-mail:________________________________________________________

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

☐ Digital book service   ☐ Audiovision (Radio Reading Service)

☐ Newsline   ☐ Books in Braille

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.
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: _______________________________________ 

Email, fax or mail completed application to:

New Jersey State Library  
Talking Book & Braille Center  
Attention: Mary Kearns Kaplan  
2300 Stuyvesant Avenue  
Trenton NJ  08618  
Email: tbbc@njstatelib.org  
Fax: 609-406-7181