APPLICATION FOR DEPOSIT ACCOUNT SERVICE

Agency Name: ____________________________________________________________

Contact Person: ___________________________________________________________

Address: _________________________________________________________________

City: ___________________ County: _______________ Zip: _______________

Telephone: ____________________ Extension: ____________________

E-mail: _________________________________________________________________

Type of Agency:

☐ Nursing Home    ☐ Hospital

☐ Adult Day Care    Other: (Specify) _______________________________

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

☐ Digital books – includes 1 player    ☐ Books in Braille

☐ Magazines in Braille

Adaptive Equipment Requested:

☐ Pillow Speaker – For bedridden readers

The New Jersey State Library Talking Book & Braille Center is supported with funds from the Institute of Museum and Library Services.
Reader Profile: Check what applies to those who will be using the service.

Books should be in: ☐ English  ☐ Spanish  ☐ Other: __________________________

Will you accept books containing:

- Strong language  ☐ YES  ☐ NO  ☐ SOME
- Graphic Violence  ☐ YES  ☐ NO  ☐ SOME
- Explicit descriptions of sex  ☐ YES  ☐ NO  ☐ SOME

Reading Level(s):

- ☐ Adult  ☐ Young Adult  ☐ Preschool
- Reading Grade Level __________ (Indicate)

Subjects

☐ Baby books (Young Readers)  ☐ History (specify)  ☐ Religion (Specify) ________________

☐ Biography (Specify) __________  ☐ Horror / Supernatural  ☐ Romance

☐ African American experience  ☐ Humor  ☐ School Stories (Young Readers)

☐ Business / Economics  ☐ Inspirational  ☐ Sea Stories

☐ Christian fiction  ☐ Jewish experience  ☐ Science Fiction

☐ Classics  ☐ Mystery  ☐ Sports __________ (specify)

☐ Contemporary fiction  ☐ Nature and Animals  ☐ Spy stories

☐ Fantasy  ☐ New Jersey settings  ☐ War stories

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□ Friendship (Young Readers)  □ Nursery Rhymes (Young Readers)  □ Westerns

□ Historical Fiction (specify)  □ Poetry  □ Women’s experience

Favorite Author(s): __________________________________________________________

AUTHORIZATION SIGNATURE

Authorization by facility 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: Adam Szczepaniak
2300 Stuyvesant Avenue
Trenton NJ 08618
Email: tbbc@njstatelib.org
Fax: 609-406-7181

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