



**APPLICATION FOR**  
**WICHITA RADIO READING SERVICE RECEIVER**

(Please Print or Type)

NAME OF PERSON USING RECEIVER \_\_\_\_\_  
ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
EDUCATION \_\_\_\_\_ BIRTH DATE \_\_\_\_\_

Does the applicant live in a Health Care Facility? NO \_\_\_\_\_ YES \_\_\_\_\_  
If yes, please give name: \_\_\_\_\_

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CO-APPLICANT: Relative or friend of the applicant who agrees to co-sign for the applicant, and be responsible for the return of the loaned receiver (if necessary), and who may be contacted for more information.

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
EMAIL \_\_\_\_\_

I, the undersigned, know that the WRRS receiver is **LOANED** to the applicant. I also understand that immediate notification of WRRS is required when service is no longer needed or wanted and the receiver must be returned to WRRS.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Call WRRS at 978-6600 to make arrangements for the return of the receiver.

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CERTIFICATION: The following must be filled out by a professional (physician, nurse, social worker, care giver) to certify the applicant cannot read conventional print or easily hold and manage reading materials.

Legally Blind \_\_\_\_\_ Partial Vision \_\_\_\_\_  
Physical Handicap (specify) \_\_\_\_\_

NAME \_\_\_\_\_ TITLE \_\_\_\_\_  
ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_  
SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PLEASE MAIL COMPLETED FORM TO: **Wichita Radio Reading Service**  
**3317 E. 17<sup>th</sup> Street**  
**Wichita, KS 67208**  
**(316)978-6600**

**A pre-set receiver may be picked up for the Applicant upon receipt and review of this form.**