Learning Ally

Qualification of Eligibility

Applicant's name: _____

Applicant's email address: _____

Applicant's/Parent's phone number: _____

For more info. select Eligibility Guide

Please have this section completed by a **Qualified Evaluator**. This information is required in order to process applicant's membership.

I confirm that the applicant qualifies for services due to the following condition:

Select all that apply:

- ◯ Reading Deficit
- ◯ Blind or Visually Impaired
- ◯ Other Physical Disability

Name of qualified evaluator: _____

Title/professional specialty: _____

Licensing Authority: _____ License No.: _____

Place of Employment: _____

Address: _____

City: _____ State: _____ ZIP/postal code: _____

Phone: _____ Email: _____

Confirm to my competency to make this qualification.

Signature: _____ Date: _____

E-mail to: CustomerCare@LearningAlly.org,
Fax to: 609.281.5900 or
Mail completed form to: Learning Ally, 20 Roszel Road, Princeton, NJ 08540