



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: 609.751.5263 or

Mail completed form to: Learning Ally, 20 Roszel Road Princeton, NJ 08540