



Disability Service Provider Application Form

Organization Name: _____
Address: _____
Extended Address: _____
City, State Zip: _____
Telephone: _____
Fax: _____
Website: _____
NAICS 2012 Code: (If known) _____

Organization Description: Please enter a brief description of your organization:

Organization Representative Contact Information

Name: _____
Job Title: _____
Office Telephone: _____ Ext: _____
E-Mail Address: _____

Please mail the completed application form to:

Universal Abilities
P.O. Box 148
Coram, New York 11727

A Universal Abilities client service manager will contact your organization representative when the application form is received.