
MATT Connect Product Registration

Contact Information

First Name: _____

Last Name: _____

School Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Serial Number

Please enter the product serial number for each item, one per line

1. _____

2. _____

3. _____

Qualification Questions

Did a HumanWare Reseller introduce you to MATT Connect, presenting all the features and benefits and offer to train and support you in the future?

YES NO

If YES please provide the name of the reseller: _____ New England Low Vision and Blindness

Please include your unique tracking code provided by the reseller: _____ NS1601

Three Ways To Submit

Email the completed form to: info@nelowvision.com

Fax completed form to our secure fax number: 844.364.2649

Mail completed form to:
New England Low Vision and Blindness
Attn: MATT Registration
799 West Boylston Street, Suite 140
Worcester, MA 01606