LIBRARY BY MAIL

CERTIFICATE OF ELIGIBILITY

To be completed by a physician, nurse, or social worker

PATIENT INFORMATION

First Name :

Date Of Birth : D D M M Y Y

Phone :

Full Address :

I certify that _____ is physically unable to travel to the library due to one of
Applicant's Name

the following:

- **Short or Long-term disability**
- **Senior Citizen non-driver (over 65 years)**
- **Pregnancy (high-risk or third trimester) or new parent (up-to 6 months after childbirth)**
- **Parent of children with homebound disability**

Certifier's Name :

Certifier's Affiliation :

Certifier's Title :

Certifier's Phone # :

Certifier's Full Address :

Certifier's Signature: _____ **Date:** _____

If disability is temporary, please estimate length: _____