



Pages 1 and 2 of this form can be filled out on your computer.  
After completing page 1 and 2 save, print and follow  
instructions on page 2 to complete rest of the form

## ***Library By Mail Application***

**(\*Required fields)**

Your full legal name\*: \_\_\_\_\_

Street address\*: \_\_\_\_\_

Facility name, if applicable\*: \_\_\_\_\_

City\*: \_\_\_\_\_ State\*: \_\_\_\_\_ Zip code\*: \_\_\_\_\_

Phone number\*: \_\_\_\_\_ Email: \_\_\_\_\_

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ (Format example: 08/01/1956)

### **Person to contact if we are unable to reach you**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Best time to be contacted:  Morning  Afternoon  Evening

Preferred method of contact:  Phone  Email  Through caregiver



Name and contact information of caregiver:

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Type of print material preferred:

Large print    Regular print    Paperback    Magazine

Type of non-print material preferred:

Books on CD    Music CD    DVD    PlayAway

How did you hear about *Library By Mail*?

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Do you have any additional comments or instructions?

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Check here to give *Library By Mail* permission to keep a record of material sent to you to avoid duplication.

Please fill out the Eligibility Requirements and Certification form on the next page, sign the agreement, and return it with this completed form. Return the form via USPS mail to:

*Library By Mail*, Glen Burnie Regional Library, 1010 Eastway  
Glen Burnie, MD 21060

The forms may also be returned to the Glen Burnie Regional Library in person.



## ***Library By Mail Eligibility Requirements***

Please check the one (1) most applicable criterion:

Chronic Illness  Visual impairment  Disability  Injury/temporary Condition

Other \_\_\_\_\_

If injury/temporary condition, how long do you expect to be homebound?

\_\_\_\_\_

### **Certification of Eligibility**

Certification of eligibility for *Library By Mail* service by a physician or other “certifying authority” is required. A “certifying authority is defined to include: doctors of medicine (physicians), doctors of osteopathy, ophthalmologists, optometrists, registered nurses, therapists, social workers or any professional approved by the librarian in charge of *Library By Mail* service at the Glen Burnie Regional Library.

A certifying authority must complete this section certifying that the applicant of the included form has the condition indicated

Name \_\_\_\_\_ Title/Occupation \_\_\_\_\_

Agency address \_\_\_\_\_ Phone \_\_\_\_\_

Certifier Signature \_\_\_\_\_ Date \_\_\_\_\_

### **Applicant Signature**

I hereby certify that I am eligible to receive *Library By Mail* service. I understand that I assume financial responsibility for the materials I receive, and for making sure the materials are returned to the Anne Arundel County Public Library.

Signature \_\_\_\_\_ Date \_\_\_\_\_