



**Library-By-Mail Homebound Services
Certification**

TO BE COMPLETED BY A HEALTH CARE PROFESSIONAL OR PROFESSIONAL CAREGIVER (Please Print):

Full Legal Name of Homebound Applicant: _____

Address of Homebound Applicant: _____

City: _____ **State:** _____ **Zip code:** _____

**Name of Health Care Professional/
Professional Caregiver:** _____

Title/Occupation: _____

Phone Number: () _____

Street Address: _____

City: _____ **State:** _____ **Zip code:** _____

I certify that the above-named applicant has requested library service and is unable to go to the Mid-Continent Public Library due to the following:

Signature: _____ **Date:** _____

Please check if applicant is unable to read or use regular printed materials:

FAX OR MAIL CERTIFICATION TO:

Mid-Continent Public Library
Adult Specialist's Office
Homebound Services
15616 E. 24 Highway
Independence, MO 64050

FOR MORE INFORMATION:

816-503-4175
816-521-7260
FAX: 816-521-7253
Email: homebound@mymcpl.org
www.mymcpl.org