Merrick Library Home Delivery Service Application

NAME _____

ADDRESS _____ **APT#** _____

CITY _____ **STATE** _____ **ZIP** _____

PHONE _____

I am a resident of Merrick (School District #25) who is unable to use the facilities of the Merrick Library because (check all that apply):

_____ I have a physical disability

_____ I have a visual disability

_____ I have a chronic illness

_____ I am experiencing a loss of mobility associated with the aging process

_____ I am a caregiver for a person with one or more of the above limitations

I give permission to the Merrick Library to keep a record of the library materials sent to me in order to avoid duplication. This information is confidential.

Signature:_____

PLEASE CHECK ALL THAT APPLY:

_____ I prefer large print books

_____ I prefer paperback books

I do not wish to receive materials that contain:

_____ Strong Language

_____ Violence

_____ Explicit Sexual Descriptions

_____ Other

Material Selection Information

Merrick Library will send specific titles you request if they are available, or materials will be chosen for you. If you wish to have materials selected for you, the Library needs information about your book and subject interests. Please check the types of books and subjects you prefer:

FICTION	**NON-FICTION**
_____Best Sellers	**_____Religion/Inspirational**
_____Mystery	**_____Biography**
_____Historical Fiction	**_____Cooking**
_____Spy/Espionage	**_____Poetry/Plays**
_____Classics	**_____Sports**
_____Short Stories	**_____History**
_____Other	**_____Other**

Favorite Authors: _____

NOTE: All Homebound Service deliveries are done biweekly at a day and time determined by the Merrick Library.

Please send this application to:

Merrick Library
2279 Merrick Avenue
Merrick, NY 11566

Tele: 516-377-6112
Reference Department
Phone Extension: 101
E-Mail: kristinedugan@merricklibrary.org

Certification of Disability

I certify that:

NAME _____

ADDRESS _____

is homebound for the reason(s) indicated at the beginning of this registration form
I am a(n):

_____Licensed Medical Doctor
_____Optometrist or Ophthalmologist
_____Registered Nurse
_____Social Worker
_____School Superintendent
_____Public Welfare Worker
_____Professional staff member of hospital or other health/social service agency

Certified by: (signature) _____

Print or type name: _____

Address: _____

Date:_____