

**Books by Mail Service Application
Certification of Disability**



I certify that

Name _____

Date of Birth (month/day/year) _____

Address _____

City _____ State _____ Zip _____

Phone _____ Date _____

is unable to use or read conventionally-printed material due to a physical or visual disability. I am a(n):

Licensed medical doctor

Ophthalmologist or Optometrist

Registered Nurse

Professional staff member of a hospital or other health/social service agency

Certified by (signature): _____

Printed or typed name: _____

Organization: _____

Date: _____