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: _____