St. Joseph Public Library

Library-By-Mail
502 North Woodbine Road, St. Joseph, MO 64506
Phone: 816-236-2107 librarybymail@sjpl.lib.mo.us Fax: 816-236-1429

Library-By-Mail Application

This application will qualify St. Joseph Public Library patrons to receive library materials, free of charge, through postal mail. This service is available to homebound persons of all ages who live in the St. Joseph Public Library District. If your disability is temporary, you are welcome to apply for this service as long as you qualify. Please fill out the application, have page two signed by a physician, ophthalmologist, optometrist, nurse, or social worker and return to Library-By-Mail by fax or address listed above.

Personal Information

Last Name:	First Name:	
Address:		
City: St. Joseph	State: Missouri	Zip:
Phone:	Date of Birth:	
Library Card Number:		
If you do not have a library card, an account will be created for you upon completion of this application.		
Please provide a second contact in the event you cannot be reached for an extended period		
Name/Relationship:	Phone:	

Homebound Status: (please circle one)

Permanent

Temporary (end date)_____

Intermittent (please explain)_____

Reading History

☐ Please check box if you give permission for the St. Joseph Public Library to keep track of your reading history to prevent duplicate materials being sent to you. All reading history will be kept confidential.

Application Signature

By signing below I understand that my library card must be in good standing and that I am responsible for all materials sent to me through the Library-By-Mail program. I agree to give immediate notice of any change of address or homebound status.

Signature: _____ Date: _____

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Homebound Certification Form

Certification allows the library to ship materials for free. Without certification the library will pay for the postage. The post office requires certification of eligibility.

TO BE COMPLETED BY A HEALTHCARE PROFESSIONAL OR PROFESSIONAL CAREGIVER.

Doctor/Ophthalmologist/Optometrist
Registered Nurse
Therapist/Counselor
Social Worker/Case Worker
Rehabilitation Staff/Professional Hospital Staff

A family member is not eligible to sign/certify this application.

Applicant Information:		
Last Name:	First Name:	
Address:		
City: St. Joseph	State: Missouri	Zip:

Healthcare Professional/Caregiver Information:		
Last Name:	First Name:	
Title/Occupation:		
Address:		
City:	State:	Zip:
Phone:		

Certifier's Signature:
I certify that the above named applicant is physically unable to travel to the St. Joseph Public Library. Signature: _____ Date: _____