Application for Free Books By Mail Program
Brigham & Women's Hospital
Kessler Health Education Library
75 Francis Street Boston MA 02115
(617) 732 8103 Fax (617) 582 6130 TTY (617) 525 7337
https://healthlibrary.brighamandwomens.org

Please print or type: **I, _____ do hereby authorize the release of the healthcare**
(Patient Name) **information indicated below to members of the United State Postal Service for the explicit purpose of verifying eligibility for participation in the Books by Mail program.**

Name: _____
First Middle Initial Last

Address: _____

City: _____ State:_____ Zip: _____

Phone: (_____)_____Email: _____

Patient/Guardian Signature: _____

Eligibility:
You may be eligible for free postage for the purpose of returning library materials. Please indicate the disability preventing you from reading standard print. **You must have your health care provider sign this form. Please return the completed form to the Kessler Library at the address above**.

__Blindness: Vision 20/200 or less, or visual field 20 degrees or less.

__Visual Impairment: unable to read for long periods of time with correction.

__Physical Disability: unable to hold a book or turn pages (or travel to library)

__Reading Disability: unable to read standard print as a result of organic dysfunction; requires a signature from a medical doctor.

__ Hearing Impairment (if you have a hearing impairment in addition to any of the above conditions).

Authorization by health care provider

(To be completed by physician, nurse, social worker. In case of reading disability certifying authority must be a medical doctor)

I certify that the applicant is unable to read or use standard print materials for the reason(s) indicated above.

_____ (_____) _____
Signature of care provider Title/Occupation Date Phone number

Print Name: _____Institution/Organization: _____