Application to receive services through Books to You

PLEASE PRINT – All sections must be completed.

Applicant contact information:

Full Name: _____ Preferred Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Sex: M _____F _____

E-mail: _____ Birth Date: _____/_____/_____

Applicant emergency contact information:

Please provide name and phone number of emergency contact:

Name:_____

Phone:_____

Please describe applicant's reason for participation in Books to You:

Provide a brief description as to why you are requesting services Books to You homebound services:

_____

_____

_____

Homebound Factor: Permanent Disability _____ Temporary Disability _____ Illness _____ Injury _____

AGREEMENT AND SIGNATURE

I hereby certify that the information on the above application is true and complete. My signature authorizes the St. Charles City-County Library District to verify any of the information on this application. I understand that information contained on my application will be verified and that misrepresentations or omissions may be cause for my immediate rejection as an applicant or my termination as a customer.

Applicant Signature: _____ Date: _____/_____/_____

Once completed please mail or fax form to:

St. Charles City-County Library District
Attn: **Extension Services Specialist**
77 Boone Hills Dr.
St. Peters, MO 63376
Fax: 636-441-3132