

**Mahopac Public Library  
Certificate of Eligibility for  
Homebound Services**

*To be completed by a medical doctor or other professional, other than the applicant's immediate family:*

I certify that \_\_\_\_\_ is eligible for  
(applicant's name)

Mahopac Public Library's homebound service as checked below:

\_\_\_\_\_ Applicant requires continuing homebound service.

\_\_\_\_\_ Applicant qualifies for temporary homebound service, until

\_\_\_\_\_  
(date)

Signature \_\_\_\_\_

Print name \_\_\_\_\_

Title and occupation \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Date \_\_\_\_\_