



4424 NW 13th Street A5
Gainesville, FL 32609
Phone 352-375-4110
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Physician Maternity / Medical Leave Form

Date: ____/____/____

To Whom It May Concern:

Your patient, _____, is currently receiving child care assistance from the Early Learning Coalition of Alachua County. The following information regarding her pregnancy is needed in order to continue providing services:

Patient's leave date: _____

Patient's expected due/delivery date (if applicable): _____

Expected length of post-partum / recovery: _____

If medically released, date parent expected to return to normal work routine: _____

If determined medically necessary, child care assistance can be provided up to 3 months of maternity leave and / or up to 3 months of medical leave for the patient's elder children. Is it recommended that the patient receives child care assistance during release from work duties and during post-partum recovery?

Please select one.

YES

NO

Signature of Physician or Midwife

Date

Physician/Clinic Name and Phone Number
(Company Stamp Here)

NOTE:

If Physician's office does not have a company stamp, all information on this form must be put on company letter head and signed by the Physician or Midwife only.

Sincerely,
Eligibility Department
Early Learning Coalition of Alachua County