



4424 NW 13<sup>th</sup> Street A5  
Gainesville, FL 32609  
Phone 352-375-4110  
Fax 352-375-4131

Physician Maternity 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 expected due/delivery date: \_\_\_\_\_

Expected length of post-partum recovery: \_\_\_\_\_

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

\_\_\_\_\_  
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