Physician’s Disability Statement

Date: _____/_____/_____

To Whom It May Concern:

Your patient, ______________________________________________, is seeking child care assistance due to his/her disability. We must have the following information in order to determine eligibility for child care assistance:

This patient’s disability is considered to be:

☐ Temporary; anticipated duration: _____________________________

☐ Permanent

Due to this permanent disability, he/she ☐ is ☐ is not exempt from work activity

__________________________________________

Signature of Physician Only

______________________________

Date

Physician or Clinic Name and phone number:

(Company Stamp Here)

______________________________

______________________________

______________________________

Thank you for your assistance,

Eligibility Department

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 only.