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 is needed in order to continue providing services:

Patient’s leave date: __________________________________________

Patient’s expected due/delivery date: (if applicable) _______________________________

Expected length of recovery: ________________________________

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

________________________________________________________________________

Signature of Physician

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 only.

Sincerely,
Eligibility Department
Early Learning Coalition of Alachua County