Early Learning Coalition of Alachua County

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

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)
_____
_____
_____

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.

Thank you for your assistance,
Eligibility Department