

Client Name: _____ **Date of Birth** _____

VERIFICATION OF DISABILITY

To Be Completed By a Licensed Physician

In order to determine the eligibility of our client listed above for child care services, please assist us by answering the questions below. Thank you

Please review and answer all questions below:

- Is there a medical disability? **YES** or **NO**
- Does disability prevent the client from being employed? **YES** or **NO**
- Is this a permanent or temporary disability? _____

*If disability is temporary: What is the anticipated start and end date of the temporary disability? Start Date _____ End Date _____

Print or Typed Name of Licensed Physician

Signature of Physician

Date

Mailing address (including city and Zip code)

Physician's License Number

Phone Number