Early Learning Coalition of Santa Rosa County
Positive Beginnings for Promising Futures

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**