Physician Statement

I, _____, give permission to release the following information to the Early Learning Coalition of Orange County for the purpose of determining my eligibility for the School Readiness program (child care assistance).

_____ _____

Parent/Guardian Signature Date

TO BE COMPLETED BY A PHYSICIAN LICENSED UNDER CHAPTER 458 OR 459, F.S.

To Whom It May Concern:

For parent/guardian listed below to qualify for child care assistance due to disability, incapacitation, or elderly, this exemption statement must be completed by a physician on their behalf.

This parent/guardian _____ (print first/last name) is:

Choose One:

- ☐ Is permanently disabled.
- ☐ Is temporarily disabled with anticipated duration: _____/_____/_____ through ____/____/____.
- ☐ Exempt from work requirements due to age.

Contact Information for Physicians or Clinic Name, Address and Phone number:

(Print or Stamp)

_____

_____

_____

Licensed Physician's Signature: _____

Licensed Physician's Name PRINTED:_____

Phone Number:_____

Date:_____