



I give consent for release of this medical information to the Early Learning Coalition of the Nature Coast (ELCNC) to determine my eligibility for child care.

Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**VERIFICATION OF DISABILITY**  
***To Be Completed By a Licensed Physician***

To the physician:

In order to determine the eligibility of our client for child care services, please assist us by answering the questions below and returning this form to us by \_\_\_\_\_.

Thank you, \_\_\_\_\_ Client Services Counselor \_\_\_\_\_ ext. \_\_\_\_\_

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Please review and answer all questions below:**

- Is there a medical disability?  Yes or  No  
Effective date of disability: \_\_\_\_\_
- Does disability prevent the client from being employed?  Yes or  No
- Is this disability:  **PERMANENT**  **TEMPORARY**  
If temporary: What is the date of the next doctor's visit? \_\_\_\_\_
- Does this disability hinder the client from caring for his/her child (ren)?  Yes or  No

\_\_\_\_\_  
**Print or Type Name of Licensed Physician**

\_\_\_\_\_  
**Signature of Physician**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Mailing Address (including City and Zip Code)**

Physicians Stamp

\_\_\_\_\_  
**Telephone Number**

\_\_\_\_\_  
**Physician's License Number**

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212 N. Main Street  
Chiefland, FL 32626  
Phone: 352-490-5855  
Fax: 352-490-6762  
Toll-Free: 877-840-5437

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Phone: 352-563-9939  
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Toll-Free: 877-336-5437

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114 N. Jumper Drive  
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