



SCHOOL READINESS PROGRAM
VERIFICATION OF DISABILITY

To the physician:

The individual named below has applied for School Readiness services. Please assist us in determining if the individual is eligible to receive services by answering the questions below and returning this form to us by _____.

Thank you,

Eligibility Analyst

Contact Information

I give consent for release of medical information to the Early Learning Coalition of the Nature Coast, which will be used to determine my eligibility for School Readiness services.

Client Name: _____

Date of Birth: _____

Address: _____

Telephone: _____

Signature: _____

Date: _____

To Be Completed by a Licensed Physician

Please answer all of the questions below:

Yes No

Date of disability diagnosis: _____

Is there a medical disability?

Is this disability due to age?

Is the disability temporary?

If temporary, date of expiration: _____

Does this disability prevent the individual from working?

Print or Type Name of Licensed Physician

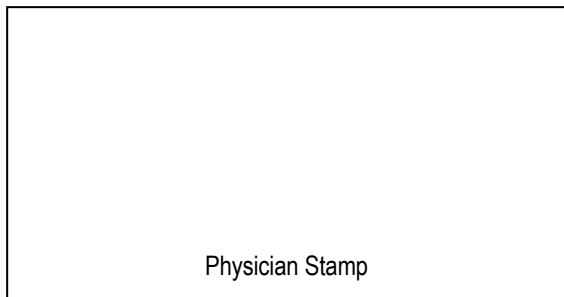
Signature of Physician

Date

Mailing Address (Including City and Zip Code)

Telephone Number

Physician's License Number



Physician Stamp