Early Learning Coalition of the Nature Coast

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
Is there a medical disability?	☐	☐
Is this disability due to age?	☐	☐
Is the disability temporary?	☐	☐
Does this disability prevent the individual from working?	☐	☐

Date of disability diagnosis: _____

If temporary, date of expiration: _____

_____ _____ _____
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

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