VERIFICATION FORM OF PERMANENT/TEMPORARY DISABILITY OR MATERNITY LEAVE

Name: _____

The individual listed above indicates that due to an event such as illness/injury/pregnancy or age, she/he is unable to work or engage in any required activities, and requires assistance to care for her/his child(ren).

Your cooperation in completing this form is needed to verify this information.

TO BE COMPLETED BY A LICENSED PHYSICIAN (PLEASE PRINT)

1. Does the clients age/circumstance prevent **any** participation in employment/training activities or limit such activities to less than 20 hours per week at this time?
   - ☐ Yes
   - ☐ No

2. a) Is this condition:
   - ☐ Permanent
   - ☐ Temporary
   - ☐ Due to Age

   b) If temporary, please indicate the estimated length of time the illness/ injury or maternity leave is expected to last:
   _____

   c) What date did this illness/injury or maternity leave begin? _____/_____/_____

3. Does this individual require assistance to care for her/his child(ren) due to this illness/injury/circumstance or maternity leave?
   - ☐ Yes
   - ☐ No

_____ _____

Physician's Name (please print) Physician's Signature

_____ _____

Physician's Office Address Date

_____ _____

City State Zip Physician's Phone Number

EARLY LEARNING COALITION of Brevard County, Inc.
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