SCHOOL READINESS PROGRAM
MATERNITY LEAVE FORM

Date: ____/____/____

To whom it may concern;

The following client ____ is currently receiving child care assistance. It is necessary that we obtain the following information from the client's physician in order to determine eligibility during maternity leave.

Please provide the following information:

The above listed client's expected due/delivery date: __________________________

The client's anticipated last date of work prior to delivery date: __________________

Due to the pregnancy, is it medically necessary for the client to receive childcare assistance while on maternity leave?

☐ Yes ☐ No (must check one)

If yes, list the reason for the temporary disability:
____
____

Physician signature _____________________________ Date ____________________________

Physician or clinic name and phone number:

(Print or stamp) ____
____
____

Thank you for your assistance.

Sincerely,
Eligibility Department

EFFECTIVE 2/2016