Community Coordinated Care for Children, Inc.
3500 West Colonial Drive, Orlando, FL 32808
(407) 522 – 2252
www.4cflorida.org

Physician's Disability Statement

Date: _____/_____/_____

To Whom It May Concern:

Your patient, _____, is seeking child care assistance due to his/her disability. We must have the following information in order to determine eligibility for child care assistance:

This patient's disability is considered to be:

- ☐ Permanent
- ☐ Temporary; anticipated duration: _____
- ☐ Maternity Leave; anticipated due date:_____/_____/_____

Physician or Clinic Name, Address and phone number:

(Print or stamp)

_____

_____

_____

_____

I declare that the above information is true and complete; I know that if I knowingly give false information, I am liable for prosecution under state law; Further, I give my consent to Community Coordinated Care for Children, Inc., The Department of Children & Families, and The Division of Public Assistance Fraud to make inquiry into the statement made above.

_____

Signature of Physician Date

Thank you for your assistance,

4C /Family Support Department