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 assistance with child care. In order to determine eligibility, we must have the following information:

This patient's disability is:

- ☐ Considered to be permanent
- ☐ Considered to be temporary, anticipated duration: ___/___/___ through ___/___/___
- ☐ High Risk Pregnancy and/or complications, anticipated duration:
  ___/___/___ through ___/___/___
- ☐ Maternity Leave, expected 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.

_____

Print Physician's Name | Signature of Physician | Date

Thank you for your assistance,

4C /Family Support Department

REVISED 2/2022