School Readiness Program
Verification of Employment/Training Disability

Recipient's Name:_____

Please complete the information for the above-named individual, who has indicated that due to an illness or injury to him/herself or due to his/her age, he or she is unable to work or engage in other activities, and child care services are needed to assist him/her in caring for his/her children. We need your assistance in order to verify this information. Your cooperation in completing this form is appreciated.

TO BE COMPLETED BY A LICENSED PHYSICIAN (PLEASE PRINT)

1. Does the illness/injury or age of above listed patient totally prevent all participation in employment/training activities at this time?

□ **Yes**
□ **No**

2. a) Is this condition:

□ **Permanent**
□ **Temporary**

b) What date did this condition begin?

_____/_____/_____

c) If temporary, please indicate the estimated length of time that the illness or injury is expected to last: _____

3. If this individual is pregnant, what is the expected date of delivery?

_____/_____/_____

4. Are Child Care services needed due to the illness/injury or age of the patient?

□ **Yes**
□ **No**

_____
Physician's Signature

_____
Please Print Physician's Name

_____
Physician's Office Address

_____
City State Zip

_____ _____
Physician's Phone Number Date

_____
CSC Signature

_____
Date