

Child Care Medical Appointment Verification

Name of the Patient:	Social Security Number:
Parent/Guardian's name (if applicable):	

To the Physician: The individual named above is requesting child care services due to their need to obtain medical services. Read the following definition and complete this form.

To be used: For the time the individual is participating in medical services, that include physicians' services, mental health services, or drug/alcohol treatment. For the time the individual is taking their child(ren) to receive medical services and cannot bring their other child(ren). For the time the individual visits their child or spouse in the hospital and cannot bring their other child(ren).

Patient receiving care? ☐ Yes ☐ No
What type of care is being received? <i>Examples: Medical, mental health, substance abuse, physical therapy, dialysis, chemotherapy etc.</i>
What is the average length of appointment(s)? If unknown, provide an estimation of time in hours.
Frequency of appointments? List how often.
How many months will these appointment continue?

Signature of Examining Physician (Medical Doctor)

Date

Type or Print Name of Examining Physician (Medical Doctor)

Street Address		
City	State	Zip

INSTRUCTIONS TO WORKER: This form is only completed if an individual requests child care services to obtain medical services. This form should be placed in the individual's case file. No additional copies are required.