1199SEIU Child Care Corporation
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1199SEIU CHILD CARE FUNDS DOCTOR'S NOTE

This form is to be completed by a physician. The 1199SEIU member should submit this completed form to SpecialNeeds@1199Funds.org for processing.

This letter serves as confirmation that _____, born on
PATIENT'S NAME

_____, has been diagnosed with the following condition(s):
MM/DD/YYYY

- ☐ Autism spectrum disorder (ASD)
- ☐ Deafness | Deaf-blindness
- ☐ Emotional disturbance
- ☐ Intellectual disability
- ☐ Multiple disabilities
- ☐ Orthopedic impairment
- ☐ Other health impairment
- ☐ Specific learning disability
- ☐ Speech or language impairment
- ☐ Traumatic brain injury (TBI)
- ☐ Visual impairment

The major life activity(ies) affected include, but are not limited to:

Activity 1	
Activity 2	
Activity 3	

Please attach additional pages if more space is needed.

Physician's acknowledgements
By signing below, I certify that these restrictions considerably influence the patient's ability to perform daily tasks at the same level as an individual without such a diagnosis. Therefore, their involvement in special needs care is crucial for their overall well-being. It is my recommendation that the patient receives special needs care. It is of the utmost importance that they be provided with an environment that is sensitive to their unique needs, based on their individual condition. Furthermore, I certify that this is a condition recognized under the Individuals with Disabilities Education Act (IDEA), and it significantly limits one or more of their major life activities, especially as it relates to special education and related services.

_____
DOCTOR'S NAME

X _____
DOCTOR'S SIGNATURE DATE OF EXAM (MM/DD/YYYY)

(This form requires physician's stamp for validation)