Department of Growth Management

Care of the Disabled or Infirm

Physician's Affidavit

The information requested below is required by the Lake County Board of County Commissioners in order to process a permit for temporary housing on the owner's property for care of a relative (by blood or marriage) that is disabled or infirm.

As a condition of the permit, there must exist a medical necessity as determined by the infirm's attending physician. As the infirm's physician, please complete the questions below in order to assist in our determination:

Patient's Name: ____

Address: ____

Physician's Name: ____

Address: ____

Date the Physician last reviewed the Patient's file____

Date the Physician last examined the Patient____

How long have you been treating the patient for the medical condition for which medical assistance is necessary? ____

I assert, with a reasonable degree of medical certainty that the patient's physical limitations may be appropriately attended to by the caregiver. _______YES _______NO

Do you anticipate the patient's medical condition(s) to be in existence for a period of time to exceed twelve (12) months? ______YES ______NO If no, please explain: ____

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The above information, provided to the Lake County Board of County Commissioners, is true and factual to the best of my medical knowledge and belief.
Signature of Attending Physician: ____

Attending Physician's Medical License # ______________________________Date: ________________

STATE OF FLORIDA
COUNTY OF LAKE
The foregoing instrument was acknowledged before me this _____ day of _______________________,20___, by ____, who is personally known to me or who has produced ______________________________________ as identification and who ______did or ______did not take an oath.

(SEAL)

____
Notary Public (Signature)

My Commission Expires: ________________________

To be completed by staff: THCI #______________________