Office of Planning and Zoning

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: _____

Phone Number: _____ Email 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: _____

_____

_____

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 #_____