Date: [Insert Date]

To: [Physician Name/Medical Clinic]
From: [Agency Name/Social Worker Name]
Subject: Annual Medical Clearance Renewal for Foster Caregiving

Dear Healthcare Provider,

Patient Name: [Foster Parent Name]
Date of Birth: [Date of Birth]

The individual named above is currently a licensed foster parent with [Agency Name]. State licensing regulations require that all foster parents undergo an annual medical evaluation to ensure they are in good physical and mental health to provide care for dependent children.

Please evaluate the patient and complete the attached medical report form, specifically addressing the following:

- Presence of any communicable diseases.
- Current physical health status and any chronic conditions.
- Mental health stability.
- Any medications that may impair the ability to supervise or care for children.
- A statement confirming whether the patient is physically and emotionally capable of caring for children in a foster home setting.

Please return the completed medical clearance form via fax to [Fax Number] or by mail to the address listed below:

[Agency Name]
[Attn: Name of Case Worker]
[Mailing Address]
[City, State, Zip Code]

If you have any questions, please contact [Case Worker Name] at [Phone Number] or [Email Address].

Thank you for your assistance in ensuring the safety and well-being of children in foster care.

Sincerely,

[Signature]
[Printed Name]
[Title/Position]