Date: [Date]

To: [Foster Care Agency Name]
Address: [Agency Address]
City, State, Zip: [City, State, Zip]

Re: Conditional Medical Clearance for [Applicant Name]

To Whom It May Concern,

I am the primary healthcare provider for **[Applicant Name]**, born on **[Date of Birth]**. I have conducted a physical examination and reviewed the medical history of the applicant to determine their suitability for becoming a foster parent.

At this time, I am providing a **conditional medical clearance**. Based on my evaluation, the applicant is physically and mentally capable of caring for children, provided the following conditions or limitations are met:

Conditions for Clearance:

- [Condition 1: e.g., Completion of physical therapy for a specific injury]
- [Condition 2: e.g., Stabilization of a specific medication dosage]
- [Condition 3: e.g., Medical follow-up required in 3 months]

Provider Comments:
[Insert additional details regarding the applicant's health status or the reasoning for the conditions here.]

Once the conditions listed above are satisfied, I will provide a final unrestricted clearance. If you have any questions regarding this assessment, please contact my office at [Phone Number].

Sincerely,

[Physician Name/Signature]
[Medical Title/Credentials]
[License Number]
[Clinic/Practice Name]