Date: [Date]

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

RE: Medical Clearance for Therapeutic Foster Care Applicant

Applicant Name: [Applicant Full Name]
Date of Birth: [Applicant Date of Birth]

To Whom It May Concern,

I have completed a physical examination and health history review for the individual named above. This evaluation was conducted to determine their physical and mental fitness to serve as a Therapeutic Foster Parent.

Based on my clinical findings, I certify the following:

- The applicant is free from any communicable or infectious diseases that could pose a threat to children in their care.
- The applicant is physically capable of performing the duties required to care for children, including those with specialized medical or behavioral needs.
- The applicant does not have any physical or mental health conditions that would impair their ability to provide a safe and stable environment for a child.
- (If applicable) The applicant's current medications do not interfere with their judgment or ability to provide 24-hour supervision.

Medical Provider's Recommendation:

[ ] The applicant is medically cleared without restrictions.
[ ] The applicant is medically cleared with the following restrictions/accommodations: [Enter Restrictions]
[ ] The applicant is not medically cleared at this time.

Sincerely,

Signature: _____
Provider Name: [Name and Title]
Medical Facility: [Clinic/Hospital Name]
Phone Number: [Phone Number]
License Number: [License Number]