**Date:** [Date]

**To:** [Foster Care Agency/Department Name]
**Attention:** [Caseworker/Licensing Specialist Name]
**Address:** [Agency Address]

**RE: Specialist Consultation Clearance**
**Patient Name:** [Foster Parent Applicant Name]
**Date of Birth:** [Date of Birth]

To Whom It May Concern,

I am writing to provide a medical clearance for the above-named individual, who is currently under my care for the management of [Specify Condition, e.g., Type 2 Diabetes, Hypertension, etc.].

The purpose of this evaluation is to determine the applicant's physical and mental stability to serve as a foster parent. Based on my clinical assessment and review of the patient's medical history, I find that:

- The patient is compliant with their current treatment plan and medications.
- The condition is currently stable and well-managed.
- There are no identified medical limitations that would prevent the applicant from providing a safe and healthy environment for a child in foster care.
- The applicant possesses the physical and emotional stamina required to meet the daily demands of parenting.

In my professional opinion, [Applicant Name] is medically cleared to participate in the foster care program without restrictions.

If you require any further information or clarification, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

**[Physician Printed Name]**
[Medical Specialty/Title]
[License Number]
[Clinic/Hospital Name]