Date: [Insert Date]

To: [Foster Care Agency Name/Department of Social Services]
Address: [Agency Address]
City, State, Zip: [City, State, Zip Code]

RE: Medical Certification for Foster Care Eligibility

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

To Whom It May Concern,

I am a licensed physician currently treating [Applicant Full Name]. I have performed a comprehensive physical examination and reviewed the medical history of the aforementioned individual on [Date of Examination].

Based on my clinical evaluation, I certify that the applicant is in good physical and mental health. I have found no evidence of communicable diseases or chronic medical conditions that would impair their ability to provide consistent care, supervision, and a safe environment for a foster child.

Furthermore, it is my professional opinion that the applicant is physically and emotionally capable of handling the routine and emergency demands associated with foster parenting.

The following health metrics were confirmed during the evaluation:

- Tuberculosis (TB) Status: [Negative/Clear]
- Immunization Status: [Up to date/As recorded]
- Current Medications: [None / List if applicable]
- Physical Limitations: [None / List if applicable]

Please feel free to contact my office at [Phone Number] if you require further documentation or clarification regarding this certification.

Sincerely,

[Physician Signature]
[Physician Printed Name, MD/DO]
License Number: [License Number]
Clinic/Practice Name: [Practice Name]
Phone: [Phone Number]