Date: [Date of Examination]

To Whom It May Concern,

This letter serves to certify that I have performed a comprehensive physical examination on the individual named below for the purpose of foster care licensure/placement.

Patient Name: [Patient First and Last Name]
Date of Birth: [Patient Date of Birth]
Address: [Patient Home Address]

Clinical Findings:

- The patient is in good physical and mental health.
- The patient is free from communicable diseases that would pose a risk to children in a household setting.
- The patient does not have any physical or mental limitations that would prevent them from providing adequate care for a child.

Immunization Status:
[ ] The patient is up to date on all recommended vaccinations.
[ ] The patient has a medical exemption for the following: [List exemptions if applicable].

Physician's Statement:
Based on my evaluation, it is my professional opinion that the applicant is physically and mentally capable of performing the duties associated with foster parenting.

Provider Information:

Signature: _____
Printed Name: [Provider Name, Degree]
Medical License Number: [License #]
Clinic/Practice Name: [Facility Name]
Phone Number: [Phone Number]