Date: [Insert Date]

To: [Agency Name / Department of Social Services]
Re: Medical Certification for Foster Care Applicant

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

To Whom It May Concern,

I am a licensed medical professional and have been providing care for the above-named individual since [Date]. I conducted a physical examination of the applicant on [Date of Exam].

Based on my examination and medical history, I certify the following:

- The applicant is in good physical and mental health.
- The applicant is free from communicable diseases that could pose a risk to children.
- The applicant does not have any physical or mental conditions that would interfere with their ability to provide adequate care, supervision, and a safe environment for a foster child.

Current Medications: [List medications or state "None"]

Additional Comments: [Optional: Enter any specific recommendations or "N/A"]

If you require further information regarding this applicant's medical status, please contact my office at [Phone Number].

Sincerely,

[Signature]
Printed Name: [Provider Name]
Title: [e.g., MD, DO, NP, PA]
Medical License Number: [License #]
Clinic/Facility Name: [Clinic Name]
Address: [Clinic Address]