Date: [Insert Date]

To: [Insert Adoption Agency Name]
Address: [Insert Agency Address]

RE: Physician Certification for Prospective Adoptive Parent

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

To Whom It May Concern,

I am a licensed physician in the state of [Insert State]. I have been the primary healthcare provider for [Insert Patient Name] since [Insert Year/Date].

On [Insert Date of Most Recent Exam], I performed a comprehensive physical examination of the patient. Based on this examination and a review of their medical history, I find the patient to be in good physical and mental health. There are no chronic conditions, communicable diseases, or physical limitations that would impair their ability to care for a child.

Specifically, I have evaluated the following:

- **Physical Health:** The patient is fit to manage the daily physical demands of parenting.
- **Communicable Diseases:** The patient has been screened and is free from infectious diseases that would pose a risk to a child.
- **Mental Health:** The patient demonstrates emotional stability and no history of mental health issues that would interfere with parenting.
- **Life Expectancy:** The patient has a normal life expectancy and is expected to be able to care for a child through their maturity.

In my professional opinion, [Insert Patient Name] is physically and mentally capable of providing a safe, stable, and healthy environment for an adoptive child. I recommend them for prospective adoptive placement without reservation.

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

Sincerely,

[Physician Signature]
[Physician Name, M.D./D.O.]
[License Number]
[Clinic/Hospital Name]
[Address]
[Phone Number]