[Clinic Name]
[Clinic Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]

[Date]

[Adoption Agency Name]
[Agency Address]
[City, State, Zip Code]

RE: Medical Verification for [Prospective Parent Name(s)]

To Whom It May Concern,

This letter is to verify that [Prospective Parent Name(s)] has/have been a patient of [Clinic Name] since [Year]. Our records indicate that [he/she/they] underwent a comprehensive physical examination on [Date of Examination].

Based on the medical history and the results of the physical assessment, it is my professional opinion that [Prospective Parent Name(s)] is/are in good physical and mental health. At this time, I find no evidence of medical conditions or physical limitations that would interfere with [his/her/their] ability to care for an adopted child or provide a safe and stable home environment.

The following health indicators were confirmed during the evaluation:

- Current Health Status: [Stable/Excellent]
- Chronic Conditions: [None/Managed as follows]
- Communicable Diseases: [None detected]
- Mental Health: [No concerns noted]
- Life Expectancy: [Normal/No limiting factors]

I recommend [Prospective Parent Name(s)] for child placement without medical reservation. If you require any additional information or have specific questions regarding this evaluation, please contact our office directly.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[Medical License Number]
[Clinic Stamp]