Date: [Insert Date]
Re: Medical Certification for Adoption
Patient Name: [Insert Patient Full Name]
Date of Birth: [Insert Patient Date of Birth]

To Whom It May Concern,

I, Dr. [Insert Physician Name], a licensed physician practicing at [Insert Clinic/Hospital Name], hereby certify that I have conducted a comprehensive physical examination of [Insert Patient Name] on [Insert Date of Examination].

Based on the medical history, physical findings, and laboratory results, I find the patient to be in good physical and mental health. The patient is free from any communicable or contagious diseases that would pose a risk to a child.

Furthermore, I have determined that the patient does not have any physical or mental limitations that would prevent them from providing adequate care, supervision, and protection for an adopted child. The patient's life expectancy is not significantly shortened by any known chronic medical conditions.

In my professional opinion, [Insert Patient Name] is medically fit to undertake the responsibilities of parenthood through adoption.

Sincerely,

[Signature of Physician]
[Typed Name of Physician]
Medical License Number: [Insert License Number]
State of Licensure: [Insert State]
Contact Phone: [Insert Phone Number]
Clinic Address: [Insert Address]

[Official Clinic Stamp/Seal]