MEDICAL REPORT ON APPLICANT FOR CERTIFICATION TO PROVIDE CARE FOR CHILDREN OR ADULTS WITH DISABILITIES

For use of this form, see AR 608-75; the proponent agency is OACSIM

NAME	DATE *(YYYYMMDD)*

FOR EXAMINING PHYSICIAN

Application is being made to obtain certification to care for children or adults with disabilities in their homes. We need to know if applicant has any health problems and the extent and significance of such problems insofar as they may affect applicant's ability to provide care to unrelated children or adults. This information is for confidential use.

CHECK APPROPRIATE BOXES AND EXPLAIN "NO" ANSWERS IN SPACE BELOW

1. IS THE APPLICANT FREE FROM ACUTE OR CHRONIC DISEASE THAT MIGHT AFFECT THE HEALTH OR DEVELOPMENT OF CHILDREN OR ADULTS UNDER CARE? ☐ YES ☐ NO

2. IN YOUR OPINION, IS THE APPLICANT FREE FROM ANY NERVOUS OR EMOTIONAL DISORDER THAT WOULD AFFECT THE WELL BEING OF THE INDIVIDUALS CARED FOR? ☐ YES ☐ NO

3. DO YOU BELIEVE THE APPLICANT IS PHYSICALLY AND EMOTIONALLY CAPABLE OF CARING FOR MENTALLY RETARDED AND/OR PHYSICALLY DISABLED CHILDREN AND ADULTS? ☐ YES ☐ NO

A CHEST X-RAY OR TUBERCULIN TEST IS REQUIRED. IF EITHER TEST HAS BEEN DONE THROUGH YOUR OFFICE WITHIN THE LAST THREE MONTHS WOULD YOU INDICATE THE DATE GIVEN AND RESULT *(POSITIVE ,OR NEGATIVE)*

CHEST X-RAY		TUBERCULIN TEST	
DATE *(YYYYMMDD)*	RESULT	DATE *(YYYYMMDD)*	RESULT

TYPED NAME AND ADDRESS OF PHYSICIAN	SIGNATURE

PERMISSION FOR RELEASE OF MEDICAL INFORMATION

I agree to the release of medical information to the ACS Respite Care Program.

SIGNATURE *(Applicant)*	DATE *(YYYYMMDD)*