

**PHYSICIAN'S STATEMENT**

**Note to the Physician:** The purpose of this examination is to determine whether the person named below as a caregiver is physically, emotionally, and mentally able to provide a home for a foster/adoptive child or for a vulnerable adult. Responsibilities of a caregiver may include: 24-hour supervision, personal care, transportation, positive behavior management, obtaining proper medical and dental care, providing follow-up care and medical treatment, and administering medication. If the person you are examining is an adult household member, the information on this form is needed to ensure that this person does not have a physical, emotional, or mental health condition that may compromise the ability of a caregiver to also care for a foster/adoptive child or a vulnerable adult.

**I give my permission for my physician to release this statement to the agency specified at the end of this form. The Physician's Statement is to be used only for the purpose of evaluating me or a household member for licensure/certification.**

PATIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

NAME OF CAREGIVER/ADULT HOUSEHOLD MEMBER (*Last, First, M.I.*) \_\_\_\_\_ GENDER \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

Male  Female

ADDRESS (*No., Street, City, State, ZIP*) \_\_\_\_\_

DATE OF MOST RECENT PHYSICAL EXAMINATION \_\_\_\_\_

HISTORY OF PAST OR PRESENT MAJOR ILLNESSES, SURGERIES OR TREATMENTS \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CURRENT STATUS OF GENERAL PHYSICAL HEALTH \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CURRENT STATUS OF GENERAL EMOTIONAL HEALTH \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HAS THE INDIVIDUAL EVER BEEN TREATED FOR MENTAL ILLNESS

Yes  No If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

HAS THE INDIVIDUAL EVER BEEN TREATED FOR EMOTIONAL PROBLEMS

Yes  No If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

HAS THE INDIVIDUAL EVER BEEN TREATED FOR DEPRESSION

Yes  No If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

Equal Opportunity Employer/Program ♦ Under the Americans with Disabilities Act (ADA), the Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service, or activity. For example, this means that if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. This document is available in alternative formats by contacting (602) 347-6340.

HAS THE INDIVIDUAL EVER BEEN TREATED FOR SUBSTANCE ABUSE

Yes  No If yes, explain:

REGULARLY PRESCRIBED MEDICATIONS AND REASONS FOR USE

WOULD ANY OF THE ABOVE REFERENCED MEDICATIONS INTERFERE WITH THE SAFE CARE AND SUPERVISION OF CHILDREN OR VULNERABLE ADULTS (e.g., drowsiness, disorientation, lack of concentration, ect.)

Yes  No If yes, explain:

IS THERE ANY MEDICAL OR EMOTIONAL PROBLEM THAT INDICATE TO YOU THAT THIS INDIVIDUAL MAY PRESENT A RISK TO, OR NOT BE ABLE TO CARE FOR, NURTURE, OR SUPERVISE CHILDREN OR VULNERABLE ADULTS (e.g., restrictions on lifting, lack of strength or stamina, unusual stressors, etc.)

Yes  No If yes, explain:

PHYSICIAN'S NAME (Please Print)

LICENSE NO.

ADDRESS (No., Street, City, State, ZIP)

PHYSICIAN'S SIGNATURE

DATE

**Please send this completed Physician's Statement to the agency specified below. If you have any questions regarding this form, the purpose of the exam, or if you wish to add to your comments, please contact the agency below.**

AGENCY SPECIALIST'S NAME

AGENCY'S NAME

PHONE NO.

AGENCY'S ADDRESS (No., Street, City, State, ZIP)

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