Department of Human Services
Child Care Services Office
2100 Washington Blvd, 3rd Floor
Arlington, Virginia 22204
(703) 228-1685 Office
(703) 228-1172 Fax

MEDICAL CERTIFICATION

To: **Examining Physician,**

Patient's Name: ____________________________________

The above patient is applying for a position or lives in a home where direct care is provided to children. It shall be determined if this patient has any health problems and the extent and significance of such problems that impact their ability to care for children.

**This information will be kept confidential.

Please answer the following items listed below. Please explain all "NO" answers in the space provided.

1. Is the patient free from acute or chronic disease that might affect the health or development of children under care? ☐ Yes ☐No (please explain)
   ____
   ____

2. Do you believe the patient is physically and mentally capable of caring for children? ☐ Yes ☐ No (please explain)
   ____
   ____

<u>Examining Physician's Information</u>

Name: ______________________________ Signature: ____________________________ Date: _____________
Please Print

Address: ____ Telephone: _____________________
Street City, State Zip