
(Family Child Care Provider's Name)

Physician's Statement for Household Member

The following adult lives in a home where child care will take place. He / She will not be responsible for the care of the children, but will have regular contact with them.

Date _____

This is to state that _____ was examined on _____
(Patient's name) (date)
and is in good physical and mental health (from the physician's perspective), and is free from tuberculosis (TB) and other communicable diseases.

TB test date _____

Test results _____ positive _____ negative

If positive, please explain. _____

Physician's signature _____

Address _____

Telephone Number _____

Note: 4C reserved the right to request a new TB/medical as needed.

Please return to:

4C Recruitment Office
Dawn Hoskins
1924 Dana Ave.
Cincinnati, Ohio 45207