

**PHYSICIAN'S STATEMENT**

The following person is applying to do child care.

Date \_\_\_\_\_

From your perspective, as a physician, this is to state that \_\_\_\_\_  
(patient's name)

was examined on \_\_\_\_\_ and is:  
(date)

**Numbers 1 through 4 must be completed for acceptance to 4C Registry.**

Yes    No

- \_\_\_\_\_ 1. In good physical health and able to care for children.
- \_\_\_\_\_ 2. In good mental health and able to care for children.
- \_\_\_\_\_ 3. Free from communicable diseases.
- \_\_\_\_\_ 4. Free from TB (Tuberculosis)\*

Test Date \_\_\_\_\_

Test Results    \_\_\_ Positive    \_\_\_ Negative

\* If your patient is currently pregnant or nursing please complete the statement below:

Yes    No

\_\_\_\_\_ \* It is understood that medically, your patient is unable to receive a TB test at this time. However, to the best of your medical knowledge this person is free from TB and other communicable diseases.

\_\_\_\_\_  
(date)

Physician's Signature \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

**Note: 4C reserves the right to request an updated TB as needed.**

4C needs original form returned.

Please return to:

4C

Dawn Hoskins

1924 Dana Avenue

Cincinnati, Ohio 45207

Fax: 513-221-0393