CHILD CARE PROVIDER

PHYSICIAN'S STATEMENT

Child Care Providers Name: ____

Address/City/State: ____

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____

Telephone Number: ____

Employer: ____

The above named person is employed at a child care facility or family child care home. This person will be responsible for the care of children. In your medical opinion, is this person capable of assuming these job responsibilities?

YES _______ NO _______

If no why not?

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Any additional comments:

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___________________________________ ____________________________

Physician's Signature Date

Physicians Name (please print): ____

Office Address:____

City:_________________________ State:______________________ Telephone:_________