MEDICAL CLEARANCE REQUEST – ADULT FOSTER CARE AND HOMES FOR THE AGED

Department of Licensing and Regulatory Affairs
Bureau of Community and Health Systems

APPLICANT/LICENSEE INFORMATION

Facility/Home Name		License Number	
Facility/Home Address (Street Number and Name)	City	State	Zip Code

PLEASE MAIL TO ➡

Licensing Consultant (Name, Address, Phone)

Department of Licensing and Regulatory Affairs
Bureau of Community and Health Systems
P.O. Box 30664
Lansing, MI 48909

License Application Type

☐ Adult Foster Care (24-Hour Care)
☐ Home for the Aged (24-Hour Care)

PATIENT INFORMATION (To be Completed by Patient) (Please Print or Type)

Name (Last, First, Middle, Jr., II, etc.)	Date of Birth	Social Security Number	Telephone Number
Address (Street Number and Name)	City	State	Zip Code

RELEASE OF INFORMATION (To be Completed by Patient)

I authorize the release of medical information concerning me to the facility/home listed above and to the Michigan Department of Licensing and Regulatory Affairs, Bureau of Community and Health Systems for the purpose of determining my suitability to provide or be associated with the care of dependent adults.	Date
	Patient's Signature
	Physician's Name (Please PRINT or TYPE)

MEDICAL INFORMATION (To be Completed by Physician)

- **This individual is, or will be, employed in a dependent adult care setting.**
- **It is necessary to establish that those providing care are in such physical and mental condition and health as not to adversely affect the health or safety of a dependent adult and the quality and manner of his/her care.**
- **To assist us in this determination, you are being asked to answer the following.**

Has this Person Been Tested for T.B.?	Date Tested	Test Type	Results
☐ No ☐ Yes If Yes ➡		☐ Skin Test ☐ X-Ray	☐ Positive (Explain in Comments) ☐ Negative

How would you describe the patient's general physical/mental condition and health? (Use Comments section for explanations)

☐ No physical/mental condition or health problem exists that would limit the ability to work with or around dependent adults.
☐ Physical/mental condition or health problem exists that would not limit the ability to work with or around dependent adults. Explain in Comments if reasonable accommodation may be needed.
☐ Physical/mental condition or health problem exists which would affect the ability to work with or around dependent adults, with or without reasonable accommodation.

Comments (Please use back of this form if additional space is needed.)

Would you like to be contacted by the licensing consultant regarding your recommendation? ☐ Yes ☐ No

Licensed Physician or his/her designee Signature	Signature Date	Telephone Number	Examination Date
Address (Street Number and Name)	City	State	Zip Code

AUTHORITY: 1973 PA 116
1979 PA 218
RESPONSE: Voluntary
PENALTY: Application for licensure may be denied.

LARA is an equal opportunity employer/program.