

MEDICAL CLEARANCE REQUEST – CHILD WELFARE LICENSING

Michigan Department of Health and Human Services

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)
 Michigan Department of Health and Human Services
 Division of Child Welfare Licensing
 PO Box 30650
 Lansing, MI 48909

License Application Type
 Child Foster Care (24-Hour Care)

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

Name (Last, First, Middle, Jr., II, etc.)	Date of Birth	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 home listed above and to the Michigan Department of Health and Human Services, Division of Child Welfare Licensing, for the purpose of determining my suitability to provide or be associated with the care of children.	Date
	Patient's Signature
	Physician's Name (Please PRINT or TYPE)

MEDICAL INFORMATION (To be Completed by Physician)

<ul style="list-style-type: none"> This individual is, or will be, caring for children in a child care setting and may be solely responsible for children birth to age 17. 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 child 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.? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes →	Date Tested (Required Only One Time)	Test Type <input type="checkbox"/> Skin Test <input type="checkbox"/> X-Ray	Results <input type="checkbox"/> Positive (Explain in Comments) <input type="checkbox"/> Negative
How would you describe the patient's general physical/mental condition and health? (Use Comments section for explanations)			
<input type="checkbox"/> No physical/mental condition or health problem exists that would limit the ability to provide independent care of children (birth to age 17) in a child care setting.			
<input type="checkbox"/> Physical/mental condition or health problem exists which would affect the ability to provide independent care of children (birth to age 17) in a child care setting, with or without reasonable accommodation. Explain in comments if reasonable accommodation may be needed.			
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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Physician's 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.		The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.	