

MEDICAL CLEARANCE REQUEST

Michigan Department of Lifelong Education, Advancement, and Potential
Child Care Licensing

APPLICANT / LICENSEE INFORMATION

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

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

Full Name (Last, First, Middle, Suffixes, etc.)		Date of Birth	Telephone Number
Address (Street Number / 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 Lifelong Education, Advancement, and Potential, 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)

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 their care. To assist us in this determination, you are being asked to answer the following:

How would you describe the patient's general physical / mental condition and health? (Explain further in the Comments)
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☐ 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.
☐ 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 further in the Comments if reasonable accommodation may be needed).

Comments (Please use back of this form if additional space is needed).
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Would you like to be contacted by the licensing consultant regarding your recommendation? ☐ Yes ☐ No
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Physician's Signature	Signature Date	Telephone Number	Examination Date
Address (Street Number / Name)	City	State	Zip Code

MILEAP is an equal opportunity employer/program.	AUTHORITY: 1973 PA 116 RESPONSE: Voluntary PENALTY: Application for licensure may be denied.
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Individuals with disabilities may contact the MiLEAP ADA Coordinator to request an alternative format to these materials.
Please visit www.Michigan.gov/ADA for a list of state ADA Coordinators.