CSO-2044
06/19

ARIZONA DEPARTMENT OF CHILD SAFETY
Office of Licensing and Regulation

CHILD WELFARE DIRECT CARE STAFF PHYSICIAN'S STATEMENT

The purpose of the **Physician's Statement** is to determine whether the patient is physically, emotionally, and mentally able to provide care for children/youth residing in licensed facilities; and is free from communicable diseases. Responsibilities may include 24-hour supervision, personal care, transportation, positive behavior management, providing follow-up care and medical treatment, and administering medication.

PATIENT'S NAME *(Last, First, M.I.)*

Current status of patient's general physical health:

Current status of patient's general emotional health, if known:

Is the patient taking any over-the-counter or prescription medications that would interfere with the ability to care for, nature, transport or the supervision of children/youth. ☐ Yes ☐ No ☐ Unknown If yes, please explain

Date of Last Tuberculosis Test Tuberculosis Test Results ☐ N ☐ P ☐ Unknown

If Unknown: Is the patient presenting with any symptoms that could indicate a communicable disease? ☐ Yes ☐ No
If Yes, explain below.

Verification of TB results shall be submitted by the patient to their employer.

PHYSICIAN'S NAME *(Please Print: First, Last, MI)*	LICENSE NO.
ADDRESS *(No., Street, City, State, ZIP)*	
PHYSICIAN'S SIGNATURE	DATE