DPHHS-CFS-033A
(Rev.2/2012)

STATE OF MONTANA

DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
CHILD AND FAMILY SERVICES DIVISION

LICENSED CARE PROVIDER MEDICAL REPORT

NAME: DATE:

ADDRESS:

INSTRUCTION TO PHYSICIAN/PSYCHIATRIST/PSYCHOLOGIST OR COUNSELOR:

The above person has applied to provide child care in a facility licensed or approved by the State of Montana, Department of Public Health and Human Services. The applicant will be a

☐ Child Foster Care/Kinship Provider ☐ Prospective Adoptive Parent ☐ Prospective Guardian

As a provider, the applicant will provide care for children by bringing them into the applicant's home~~,~~, and will be responsible for the children's safety and well-being. The applicant's duties and responsibilities will include:

To assist us in our evaluation, we would appreciate the following information on the applicant.
On the applicant's self statement of personal health, the applicant indicated that there is or was a physical or mental health condition in regard to:

1. What, if any, are the limitations on the applicant's ability to provide care in relationship to the stated physical or mental health condition?

2. Are there any additional health or other conditions that could affect the applicant's ability to provide the care as identified above that you wish to comment on? Please indicate the nature of the condition and the extent of the effect:

-over-

2. (continued)

(SIGNATURE OF REPORTING PHYSICIAN) (DATE)

ADDRESS:

I authorize the sending of this report to the State of Montana, Department of Public Health and Human Services/Child and Family Services Division at the address designated below. I understand that this information is confidential and to be used by the Department of Public Health and Human Services/Child and Family Services Division for the administration of the licensure program. I hereby consent to the use of this information for such purposes.

(SIGNATURE OF APPLICANT) (DATE)

(Use this space for comments)

(If additional space is needed, please attach additional pages)

PLEASE RETURN TO: