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Dear Medical Provider:

Seattle Home Studies provides home study services to Washington State residents planning to adopt a child within the United States.

- _____
- has applied with Seattle Home Studies,
 - lives in the home of an applicant, or
 - will be participating in the in-home care of an adopted child.

Every home study applicant and every adult who will live in the home and/or participate in the in-home care of an adopted child must complete a full medical exam. The purpose of this exam is to ensure that the home study applicant or caregiver is in good emotional and physical health, and is suitable to provide care to an adopted child.

As soon as possible, please copy the following form onto letterhead (if possible), complete in ink, and return to applicant.

Thank you for your time and assistance with this matter. Should you have any additional questions, or should you wish to discuss this process confidentially, please do not hesitate to call the number listed above.

Sincerely,

Claire Greenhill, MS, LMHC
Independent Home Study Provider

Medical Form for Home Study Applicant

Patient's full name: _____

Patient's date of birth: _____

This person has been a patient in my care since (date): _____

I last examined this person on (date): _____

Please check the appropriate boxes below:

✓

	This person is in good emotional and physical health.
	This person is not addicted to drugs.
	This person is not suffering from a mental illness.
	This person is free from communicable diseases (ex: syphilis, TB, HIV/AIDS).
	I have concerns that the following conditions may affect this applicant's ability to provide a stable, healthy home to an adopted child (please provide appropriate documentation): _____ _____
	I have found no conditions that would prevent this person from providing a stable, healthy home to an adopted child.
	I recommend that this person be allowed to parent a child through adoption AND/OR participate in the care of an adopted child.

Printed name of physician: _____

Business address: _____

Business phone: _____

Signature of physician: _____

License number: _____

Date: _____