STATE OF RHODE ISLAND
DEPARTMENT OF CHILDREN, YOUTH AND FAMILIES

PHYSICIAN'S REFERENCE FOR FOSTER PARENT

Date: ____________________

An application to be a foster parent has been received from: ____
Name

____
Address

As this is frequently a physically and emotionally demanding job, the Department of Children, Youth and Families is interested in the health of the applicant.

In order that we may expedite the processing of the application, we ask that you complete this form at your earliest convenience and return it to: ____

____

What is your impression of the applicant's general health? ____

____

Does the applicant have any chronic disease or illness? [ ] Yes [ ] No

If Yes, please explain: ____

____

Do you consider the applicant physically, mentally, and emotionally competent to be a foster parent?
[ ] Yes [ ] No

If No, please explain: ____

____

Any additional comments? ____

____

____
Physician's Name and Address (Please Print)

____
Physician's Signature   Date

NOTE: THE DCYF #007B, AUTHORIZATION TO OBTAIN CONFIDENTIAL INFORMATION SHALL BE FORWARDED TO THE PHYSICIAN ALONG WITH THIS FORM.