

FORMULARIO PARA EXAMEN MEDICO/ PHYSICIAN STATEMENT



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Favor tener el selló del Doctor estampado en este formulario para que no sea devuelta y no se demore su proceso.

Favor completar la siguiente parte si usted es un proveedor(a), asistente, reemplazo, miembro de familia o sustituto(a)

Nombre del paciente: _____ Ciudad: _____

Yo estoy solicitando ser un proveedor asistente reemplazo sustituto(a) o miembro de familia (favor indique)

Yo autorizo al Dr.: _____ que de información sobre mi estado de salud a **Community Coordinated Child Care** con respecto a mi solicitud para ser una proveedora(o) registrada.

Firma: _____ Fecha: _____

Si la paciente es una asistente favor indicar el nombre de la proveedora(o) y la ciudad:

To be completed by physician:

The above named patient is applying for registration as a family day care provider or provider assistant. New Jersey State regulations require a physician's statement verifying the applicant is in good health, free from communicable disease and able to care for children. To assist us in evaluating the applicant, we are asking you to answer the questions below to the best of your knowledge. For further information, please contact: **Sandra Lee-Chow at Community Coordinated Child Care** (telephone): (973) 923-1433 ext. 137.

1. Has the patient been tested for communicable TB? (yes or no) If yes, please state: Date: _____ Test: _____ Results _____

(Note: A Mantoux test is required with 5 TU of PPD tuberculin. A tine test is not acceptable. A chest x-ray is required if the patient has had a previous positive Mantoux test.)

2. Does the patient regularly take medication? _____ Yes or _____ No.
If yes, could this medication adversely affect his or her ability to care
for children? _____(yes or no) if yes, please explain
why: _____

3. Does the patient have a current communicable disease?
_____ (yes or no) if yes, please describe:

4. How would you describe the patient's general physical and mental
health?

(Check A, B or C)

A. _____ Good physical and mental health, no limitations for work
with children.

B. _____ Health problem, but no limitations for work with children.

Please explain:

C. _____ Health problem that would limit ability to work with children.

Please explain:

Physician's signature: _____

Physician's name (please print): _____

Office address: _____

Telephone: _____ Date of examination _____