PHYSICIAN'S REPORT FOR ADOPTIVE PARENT

Date:___________________________ Exam Date:_____________________

Patient Name____________________________________ Date of Birth__________

Address____

Phone:____

Weight:____________________________ Height_____________________________

Does this patient have any medical or psychiatric problems that could affect his ability to be an adoptive parent? Yes_____ No______

Does this patient have normal life expectancy? Yes_____ No______

Doctor's Name, ____

Doctors Signature____

Address____
____

I certify that this is a true document and my physician in my presence has signed this document.

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Adoptive Father's Signature

Ed: 12/3/13