

**SAMPLE**

**SUBMIT TWO  
ORIGINALS PER  
PERSON**

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**CERTIFICATE OF HEALTH  
(MUST BE TYPED)**

**Doctor's Letterhead**

Date

To Whom It May Concern:

This medical certificate was issued for \_\_\_\_\_ who has been in my care for \_\_\_\_\_ years/months. He/She is in good over all health.

He/She has no communicable diseases including tuberculosis, AIDS, or Hepatitis.

He/She does not have a mental illness or a history of chemical dependency.

He/She is physically, mentally and emotionally able to parent a child/children.

Sincerely,

Doctors Signature and Stamp

County of                    }  
State of                       }

Sworn to and subscribed before me on this \_\_\_\_\_ day of \_\_\_\_\_,  
20\_\_\_\_.

\_\_\_\_\_  
Notary Public