

**MEDICAL CERTIFICATE  
For Prospective Adoptive Parent**

Family name, first, name, middle name: \_\_\_\_\_

Date and place of birth: \_\_\_\_\_

Place of permanent residence (address): \_\_\_\_\_

\_\_\_\_\_

**Results of Medical Examination**

Dermatologist (skin diseases): \_\_\_\_\_  
(Diagnosis) (Date)

Gynecologist/Proctologist (sexually transmitted diseases): \_\_\_\_\_

\_\_\_\_\_ (Diagnosis) (Date)

Psychiatrist (psychological/mental diseases): \_\_\_\_\_  
(Diagnosis) (Date)

Phthysiologist (TB specialist): \_\_\_\_\_

\_\_\_\_\_ (Diagnosis) (Date)

Narcologist (drug/alcohol abuse): \_\_\_\_\_  
(Diagnosis) (Date)

**Blood Tests**

Wasserman reaction (syphilis test): \_\_\_\_\_

\_\_\_\_\_ (Date, number, result)

HIV \_\_\_\_\_

\_\_\_\_\_ (Date, number, result)

Conclusion: \_\_\_\_\_

\_\_\_\_\_

Doctor \_\_\_\_\_  
(Printed name) (License# if available) (Signature)

Clinics or doctors  
Seal (if available)

\_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ day of

\_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_  
(Signature of Notary Public)