BRITISH COLUMBIA | Ministry of Children and Family Development

PHYSICIAN'S REPORT ON APPLICANT

The personal information requested on this form is collected under the authority of and will be used for the purpose of administering the *Adoption Act* and/or the *Child, Family and Community Act* (CFCS Act). Under certain circumstances, the collected information may be subject to disclosure as per the CFCS Act and/or the *Freedom of Information and Protection of Privacy Act*. If you have any questions about the collection, use or disclosure of this information, please call Enquiry BC at 1 800 663-7867 and ask for the listing for the Child Welfare Policy Office or the Adoption Division.

A physician's report is required for the homestudy process. Please use a pen and print clearly.

Clear Form

TO BE COMPLETED BY THE APPLICANT

SECTION 1 APPLICANT(S)

APPLICANT'S NAME (First, Middle and Last)		
2ND APPLICANT'S NAME (First, Middle and Last)		
HOME ADDRESS		PHONE NUMBER ( ) -
CITY/TOWN	PROVINCE	POSTAL CODE

SECTION 2 APPLICANT'S PHYSICIAN

PHYSICIAN'S NAME		PHONE NUMBER ( ) -
OFFICE ADDRESS		
CITY/TOWN	PROVINCE	POSTAL CODE

SECTION 3 MCFD OFFICE CONTACT INFORMATION*

NAME OF WORKER		PHONE NUMBER ( ) -
MCFD MAILING ADDRESS		
CITY/TOWN	PROVINCE	POSTAL CODE

* Contact your Resource/Adoption worker to obtain the mailing address. For assistance in locating a worker in your region, contact Enquiry BC at 1–800–663–7867 or check the blue pages of your telephone directory for the MCFD office nearest to you.

SECTION 4 CONSENT

Please provide the Ministry any pertinent medical information, in order to establish my/our physical and emotional ability to care for children and help the Ministry of Children and Family Development assess my/our suitability to meet the needs of a child through adoption or fostering.

I consent to the disclosure of the information and permit you to release the information to the Ministry for the period of one year, or until this date (YYYY/MM/DD): _____ , or when this condition/event (please specify) _____ is complete. I am aware that I can revoke my consent at anytime by notifying the MCFD office (identified in Section 3) in writing. I also authorize you to discuss the contents of this report with my worker.

APPLICANT'S SIGNATURE	DATE (YYYY/MM/DD)
2ND APPLICANT'S SIGNATURE	DATE (YYYY/MM/DD)

TO BE COMPLETED BY THE PHYSICIAN

Please use a pen and print clearly. If more space is required, please attach separate sheets. For the purpose of this report, examination means any physical examination, laboratory test, or other assessment which in the opinon of the physician is necessary to assess the physical and mental health of the applicant to be a caregiver for children. We appreciate your answers to the following questions.

1. On what date did you examine the applicant(s) for this report?

   1st Applicant: _____ (DATE (YYYY/MM/DD)) 2nd Applicant: _____ (DATE (YYYY/MM/DD))

2. How long has the applicant(s) been known to you? Since:

   1st Applicant: _____ (DATE (YYYY/MM/DD)) 2nd Applicant: _____ (DATE (YYYY/MM/DD))

3. Please describe any health problems that could affect the applicant's ability to provide for the physical, emotional and personal care of the child(ren) now and in the future.

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4. To your knowledge, has the applicant ever received or required treatment for any emotional problems? ☐ No ☐ Yes
   If yes, please specify the nature of the problem and the type and dates of any treatment received.

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5. To your knowledge, has the applicant ever received or required psychiatric treatment? ☐ No ☐ Yes
   If yes, please specify the nature of the problem and the type and dates of any treatment received.

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6. To your knowledge, has the applicant ever received or required treatment because of use of drugs and/or alcohol? ☐ No ☐ Yes
   If yes, please specify the nature of the problem and the type and dates of any treatment received.

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7. To your knowledge, has the applicant ever received or required treament because of domestic violence? ☐ No ☐ Yes
   If yes, please specify the nature of the problem and the type and dates of any treatment received.

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8. Please comment on the applicant's general health and give your opinion as to whether the applicant's physical and mental health enables them to undertake and follow through with the responsibilities of an adoptive parent or foster caregiver.

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PHYSICIAN'S SIGNATURE	DATE (YYYY/MM/DD)

When completed, please mark as "PERSONAL AND CONFIDENTIAL" and return to the worker at the address as identified in Section 3