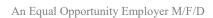
Nombre (Primer nombre, Segundo nombre, Apellido	0)	Fecha de nacimiento	Teléfono
Dirección: Calle	Ciudad	Estado	Código Postal
AUTORIZACIÓN PARA LA REVELACIÓN DE INF exclusivamente para mi solicitud como proveedor d		ICA: Autorizo la revelación de e	esta información
Firma del solicitante de cuidado infantile		Fec	ha
(Esta sección s	será llenada por e	el profesional de atención mé	<u>lica)</u>
THIS SECTION TO B	BE COMPLETED E	BY THE HEALTH CARE PROFE	ESSIONAL
As part of the application process for approval as a child care provider, a statement from a physician, physician's assistant, advanced registered nurse practitioner, or registered nurse under the supervision of a physician, is required to address the following:			
1. Do you have reason to believe the applicant has a communicable or infectious disease <u>that would present a health or safety</u> risk to a child placed in the applicant's care? TYES NO			
2. Has the applicant previously had or does the applicant currently have a medical condition that would present a health or safety risk to a child placed in the applicant's care? YES NO			
3. Does the applicant have a physical limitation, mental illness, alcohol or drug problem, significant history of physical or menta illness, or other health condition that would interfere with the applicant's ability to provide child care? YES NO			
4. Does the applicant currently take prescription med	dication that would	interfere with the applicant's ab	ility to provide child care?

5. Would responsibility for a child or children pose a potential risk to the applicant's health? **YES NO**

Physician's/Health Care Professional's Signature or Stamp

Address

Cabinet for Health and Family Services Web site: http://chfs.ky.gov/



Phone Number

Date



Ν

Kentua

Title