CCA-0039A FORFF (12-22)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Child Care

MEDICAL STATEMENT

GENERAL INFORMATION

Patient's Name *(Last, First, M.I.)*: _____ Date of Birth *(M/D/YYYY)*: _____

Address *(No., Street)*: _____

City: _____ State: _____ ZIP Code: _____

HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name *(Last, First)*: _____

License or Certificate No.: _____ Issuing State and/or Country*: _____

Health Care Provider's Address *(No., Street)*: _____

City: _____ State: _____ ZIP Code: _____ Phone No.: _____

Type of Health Care Provider

☐ Physician ☐ Physician's Assistant ☐ Registered Nurse ☐ Registered Nurse Practitioner

*The license or certificate issued by another state or country may not be accepted if it cannot be verified.

RESULTS OF SCREENING AND DIAGNOSTIC PROCEDURE FOR TUBERCULOSIS

Mantoux Tuberculin Test		**Chest X-Ray**	
Date Applied:	Date Read:	Date of X-ray:	Date of Interpretation:
Result: ☐ Negative ☐ Positive		Interpretation: ☐ Normal ☐ Abnormal	

Comments:

THIS WILL CERTIFY THAT, I the health care provider; currently licensed or certified to practice in the medical field, have examined the patient named above and find him/her to be [☐ Free ☐ Not Free] from tuberculosis in a communicable format, at the time of examination.

Healthcare Provider Signature: _____ Date: _____

IMMUNIZATION RECORDS

Rubella: ☐ Yes ☐ No ☐ NA Measles: ☐ Yes ☐ No ☐ NA Pertusis: ☐ Yes ☐ No ☐ NA

Diphtheria: ☐ Yes ☐ No ☐ NA Polio: ☐ Yes ☐ No ☐ NA Tetanus: ☐ Yes ☐ No ☐ NA

Date of Diphtheria: _____ Date of Tetanus: _____

Comments:

THIS WILL CERTIFY THAT, I the health care provider; currently licensed or certified to practice in the medical field, have acknowledged that the patient named above is up to date on the immunizations as indicated on this form.

Healthcare Provider Signature: _____ Date: _____