Department of Public Health and Social Services
Division of Children's Wellness
Bureau of Child Care Services
Location: 130 University Drive Castle Mall Unit #15 Mangilao, GU 96913
Telephone (671)735-7344 or (671)735-7256

MEDICAL EXAMINATION REPORT

Dear Dr. _____:

The Bureau of Child Care Services is conducting an assessment on our client, _____. This client has told us of an inability to work because of a medical, physical, mental, or emotional problem or is being identified as the caretaker for an individual who needs a full or part time caretaker. **Complete #3 for caretaker information.** Please help us verify the information given to us by completing the form below.
Please Note: It is ultimately the client's responsibility to provide us with this documentation.

Name of Patient: _____ DOB: _____

The signature below indicates authorization for release of information.

_____ _____
Signature of Patient/Caretaker Date Signature of BCCS Staff Date

PHYSICIAN'S CERTIFICATION

Based on my examination of the above-named person on _____, this person is:

1. [ ] in good health and is employable.

2. [ ] in poor health, but may be able to work with the following limitations and/or instructions
(Please complete the table below.)

PHYSICAL ACTIVITIES	NO LIMIT	LIMITED	TO BE AVOIDED
WALKING			
STANDING			
STOOPING			
KNEELING			
LIFTING			
REACHING			
PUSHING			
PULLING			

WORKING CONDITIONS	NO LIMIT	LIMITED	TO BE VOIDED
OUTSIDE			
INSIDE			
HUMID			
DRY			
DUSTY			
SUDDEN TEMP. CHANGE			

3. [ ] in poor health (the impairment is severe enough) that the patient needs a full-time caretaker from _____to_____.

This patient's caretaker is identified as: _____.

4. [ ] pregnant; estimated date of confinement (EDC) is on _____; and **SHOULD NOT** work from _____to_____ due to_____
_____.

5. [ ] pregnant; estimated date of confinement (EDC) is on _____; and **CAN** work with the following limitations/instructions (if any):_____.

DISABILITY: Temporary or Permanent

6. [ ] temporarily incapacitated since _____ due to _____
_____ and may return to work on _____.

7. [ ] permanently and totally disabled since _____ due to _____
_____.

Is patient fit to enter employment/training? ☐ **YES** ☐ **NO** **If Yes,** ☐ **Full Time** ☐ **Part Time**

REMARKS:_____

_____

Physician's Signature:	Stamp/Print Name of Physician/Clinic/Hospital:	Date: