West Virginia Department of Health and Human Resources

Statement of Good Health for
Informal, Relative and In-Home Providers

Provider Name_____ **Date of Birth**_____
(Last) (First) (Middle)

MEDICATIONS:

Is the patient on any medication that might impact the ability to care for children? If so, please describe below:

_____

_____

PHYSICAL/MENTAL HEALTH

Is the examiner the regular family physician for the patient? ☐ Yes ☐ No
Is the examiner aware of any physical conditions(s) that might prevent the patient from performing tasks typically required of the child care provider, such as: moving quickly to supervise young children: lifting children, equipment or supplies: hearing and seeing at a distance for playground supervision or driving? ☐Yes ☐ No If so, please describe below:

_____

_____

Is the examiner aware of any mental health condition (s) that might impact the patient's ability to provide a safe and emotionally healthy environment for young children? ☐Yes ☐No
If so, please describe below:

_____

_____

Is the examiner aware of any medical condition present in the patient which poses a public health risk? ☐Yes ☐ No. If so, please describe:

_____

_____

Signature_____ **MD/DO/PA/CRNP**
Exam Date _____

ECE-CC-3B
(05/2008)