**(Dr’s Letterhead)**

**Medical Certificate**

(Must be completed by MD)

I, ………………………., have examined Mr./Mrs. ……………………… and have reviewed all of the medical documentation concerning his/her past and present physical condition.

I certify that I have examined Mr./Mrs.………………………………………………………… referred to as the “patient” below and can answer the following questions in regards to their health:

1. Does the patient have any chronic illness? (Y/N)………………
2. Does the patient have any contagious venereal disease? (Y/N)………………
3. Does the patient show any signs and/or have a diagnosis of AIDS, tuberculosis and/or any other life threatening disease? (Y/N)……………………………

Type of Illness:………………………………………………………………………………

……………………………………………………………………………………………….

……………………………………………………………………………………………….

Official Diagnosis:…………………………………………………………………………..

………………………………………………………………………………………………

………………………………………………………………………………………………

Date of Diagnosis:…………………………………………………………………………..

Is the Illness Cured and/or in Remission:……………………………………………………

……………………………………………………………………………………………….

……………………………………………………………………………………………….

Date of Cure and/or Remission…………….……………………………………………….

Future Prognosis…………………………………………………………………………….

………………………………………………………………………………………………

………………………………………………………………………………………………

**CONCLUSION:** I hereby attest the conducted medical exams and analysis shows the reported chronic illnesses will not dramatically impact Mr./Mrs………………………. life expectancy or ability to parent an adopted child. I certify that Mr./Mrs………………….. is fully capable of being a parent. The patient is in a good physical and mental health and does not suffer from any other serious chronic diseases, contagious venereal diseases, tuberculosis and other diseases that are a menace to his/her life.

The results from the serological testing for HIV are negative.

He/She is in good mental health and is suited to adopt a child outside of the country.

**The certificate of health is issued on behalf of Mr. /Mrs./ …………………………………..to be used for the purpose of their international adoption.**

Physician’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

License #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ a Notary Public, do hereby certify that on this \_\_\_ day of \_\_\_\_\_\_ 20\_\_\_, personally appeared before me, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, personally known to me to be the person whose name is subscribed to this instrument, and acknowledged they executed the same.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Notary Public

UNITED STATES OF AMERICA

COUNTY OF \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE OF \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Commission no: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_