

Ohio Department of Job and Family Services
**MEDICAL STATEMENT FOR TYPE B HOME
 AND IN-HOME AIDE CHILD CARE PROVIDERS**

To the physician, physician's assistant (PA), advanced practice nurse (APN), certified nurse midwife (CNM) or certified nurse practitioner (CNP): The completion of the form is required before this applicant can be certified as an in-home provider for child care services. Child care services includes the full time or part time care of up to six children ages birth to thirteen years.

All sections of this form must be completed.

| | | |
|-----------------------------|---------------|----------|
| Name of Child Care Provider | Date of Birth | |
| Street Address | | |
| City | State | Zip Code |
| Date of Exam | | |

This is to certify that I have examined the above named person who I have found:

- Yes No Is free from communicable disease.

- Yes No Has been immunized against measles and mumps, or was born before December 31, 1956 and has a disease history of measles and mumps, or is exempt from this requirement for medical or religious reasons. If exempt, please explain:

- Yes No Has been immunized against rubella, or has a laboratory test demonstrating detectable rubella antibodies, or is exempt from this requirement for medical or religious reasons. If exempt, please explain:

- Yes No Is free from tuberculosis as verified by a current TB test :____ (date).

- Yes No Has been immunized against Tetanus and Diphtheria or is exempt from this requirement for medical or religious reasons. (At the time the next booster for Tetanus and Diphtheria is due, the provider or in-home aide must also be immunized against Pertussis.) (Tdap) If exempt, please explain:

- Yes No Is free from any known physical or mental health problems which might interfere with the safety or health of children, or might prohibit this individual from providing adequate care for a group of young children in a home setting. If not, please explain:

| | | |
|---|------------------|----------|
| Printed name of Physician, PA, APN, CNM or CNP | Telephone Number | |
| Street Address | | |
| City | State | Zip Code |
| Signature of the examining Physician, PA, APN, CNM or CNP | | |

This prescribed form is used to meet the requirements of Chapter 5101:2-14 of the Ohio Administrative Code.