ARIZONA DEPARTMENT OF ECONOMIC SECURITY

Division of Developmental Disabilities ● Office of Licensing Certification & Regulation (OLCR)

HEALTH SELF-DISCLOSURE

The Health Self-Disclosure and Physician Statement must be dated within six months of the submission date of the application

PATIENT'S NAME _____ GENDER ☐ M ☐ F BIRTHDATE _____
(Last, First, M.I.)

ADDRESS (No., Street, City, State, ZIP) _____

DATE OF MOST RECENT PHYSICAL EXAMINATION _____

Respond to each of the following. The disclosure of a health condition will NOT automatically preclude licensure.

I have a History of:	Yes	No	I have a History of:	Yes	No	I have a History of:	Yes	No
Alcohol Abuse	☐	☐	Diabetes	☐	☐	High Blood Pressure	☐	☐
Asthma/Respiratory Problems	☐	☐	Drug Abuse	☐	☐	HIV/AIDS	☐	☐
Autoimmune Disease	☐	☐	Epilepsy	☐	☐	Mental Illness	☐	☐
Cancer	☐	☐	Heart Disease	☐	☐	Tuberculosis	☐	☐
Chronic Pain Disorder	☐	☐	Hepatitis	☐	☐	Other:	☐	☐

EXPLAIN ANY "YES" ANSWERS TO THE ABOVE AND IDENTIFY THE TREATING PHYSICIAN/SPECIALIST

SUMMARY OF PAST OR PRESENT MAJOR ILLNESSES, SURGERIES OR TREATMENTS

I HAVE RECEIVED SERVICES OR TREATMENT FOR A PSYCHIATRIC DISORDER, EMOTIONAL PROBLEM, OR DEPRESSION

☐ Yes ☐ No If yes, explain:

I HAVE RECEIVED SERVICES OR TREATMENT FOR SUBSTANCE ABUSE

☐ Yes ☐ No If yes, explain:

I regularly use the following over-the-counter and prescription medications.

Medication	Reason for Use	Medication	Reason for Use

I certify that the information provided above is true, accurate, and complete. I understand that providing false information or the intentional misrepresentation of information on this Disclosure may result in the denial or revocation of my license/certification. I give permission for my physician to release this medical information to the agency specified at the end of the form. The Health Self-Disclosure and the Physician's Statement are to be used only for the purpose of evaluating me or a household member for licensure/certification.

PATIENT'S SIGNATURE _____ DATE _____

See reverse for EOE/ADA/LEP/GINA disclosures

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PHYSICIAN'S STATEMENT

Please review the Health Disclosure on page 1 of this form. The purpose of the **Physician's Statement** is to determine whether the patient is physically, emotionally, and mentally able to provide a home for a child with developmental disabilities or for a vulnerable adult. Responsibilities may include: 24-hour supervision, personal care, transportation, positive behavior management, providing follow-up care and medical treatment, and administering medication.

PATIENT'S NAME _____ LENGTH OF TIME IN YOUR CARE _____
(Last, First, M.I.)

CURRENT STATUS OF PATIENT'S GENERAL PHYSICAL HEALTH

CURRENT STATUS OF GENERAL EMOTIONAL HEALTH, IF KNOWN

WOULD ANY OF THE OVER-THE-COUNTER OR PRESCRIPTION MEDICATIONS REGULARLY USED BY THE PATIENT INTERFERE WITH THE SAFE CARE AND SUPERVISION OF CHILDREN OR VULNERABLE ADULTS *(e.g., drowsiness, disorientation, lack of concentration, etc.)*

☐ Yes ☐ No If yes, explain:

DOES THIS PATIENT HAVE A MEDICAL, EMOTIONAL, OR OTHER CONDITION THAT COULD INTERFERE WITH THE ABILITY TO CARE FOR, NURTURE, OR SUPERVISE CHILDREN OR VULNERABLE ADULTS *(e.g., restrictions on lifting, lack of strength or stamina, unusual stressors, communicable disease, etc.)*

☐ Yes ☐ No If yes, explain and provide your recommendations to limit risk to the health or well-being of either the patient or children/vulnerable adults placed in the home.

PHYSICIAN'S NAME _____ LICENSE NO. _____
(Please Print)

ADDRESS (No., Street, City, State, ZIP) _____

PHYSICIAN'S SIGNATURE _____ DATE _____

Please send this completed Physician's Statement to the agency specified below. If you have any questions regarding this form, the purpose of the exam, or if you wish to add to your comments, please contact the agency below.

AGENCY SPECIALIST'S NAME _____

AGENCY'S NAME _____ PHONE NO. _____

AGENCY'S ADDRESS (No., Street, City, State, ZIP) _____