OCFS-LDSS-7039 (12/2008)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

Assistant Medical Statement

INSTRUCTIONS

- A Health Care provider's signature is required in both sections of this form
- If any of the pre-filled information is incorrect, please cross out, and enter the correct information
- Please print clearly
- Maintain on Site.

Provider Name:	Group Family Day Care Program Name:
Assistant's Name:	Assistant's Date of Birth:

Tuberculin Test Information

DATE OF TEST: / /	**TB TEST HEALTH CARE PROVIDER**
MANTOUX RESULT: ☐ POSITIVE ☐ NEGATIVE ______ mm	SIGNATURE: **X**
IF APPLICANT WAS PREVIOUSLY POSITIVE, INDICATE DATE: / /	NAME:
IF POSITIVE: WAS CHEST EX-RAY ORDERED? ☐ YES ☐ NO **IF NO,** ATTACHE HEALTH CARE PROVIDER'S STATEMENT INDICATING WHY IT WAS NOT ORDERED. **IF YES,** IS CHEST X-RAY NORMAL? ☐ YES ☐ NO IF NO, ATTACH HEALTH CARE PROVIDER'S STATEMENT DOCUMENTING TREATMENT AND FOLLOW-UP.	TITLE: PHONE: DATE: / /

Medical Condition

On the basis of my findings and on my knowledge of the above-named individual, I find that he/she is fit to provide child care and is not currently exhibiting signs or symptoms suggestive of a communicable disease that could be transmitted during child care. ☐ Yes ☐ No

COMMENTS:

MEDICAL CONDITION HEALTH CARE PROVIDER
SIGNATURE: **X**
NAME:
TITLE:
PHONE:
DATE: / /