



Section 1: Completed by Applicant

Kutaa 1: Iyyataatiin kan guutamedha

MEDICAL PROVIDER NAME

MAQAA DHIHEESSAA WALLAANSA FAYYAA

PHONE NUMBER

LAKKOOFSA BILBILAA

FAX NUMBER

LAKKOOFSA FAKSII

ADDRESS OR NAME AND LOCATION OF MEDICAL OFFICE/PRACTICE/CLINIC

TEESSOON YKN MAQAA FI BAKKA WAAJJIRA WALLAANSA FAYYAA/HOJII/KILIINIINKAA

NAME OF APPLICANT

MAQAA IYYATAA

DATE OF BIRTH

GUY YAA

DHALOOTAA

I hereby authorize my medical provider to release my medical history information including, but not limited to, information on the issues I have checked below. This information is required as part of a home study for foster care and/or adoption. This release of information is valid for one year from the date of my signature.

NOTE: Be sure to check each line and sign.

mental health

sexual and/or physical abuse

alcohol and drug concerns

domestic violence

Dhimmoota armaan gaditti ilaale dabalatee odeeffannoo seenaa wallaansa fayyaa koo akka gadhiisu dhiyeessaan yaalaa koo kanaan hayyama kenna. Odeeffannoon kun akka qaama qorannoo bakka kunuunsa kennuufi/ykn guddisaa manaatiif ni barbaachisa.

Odeeffannoon gadi dhiifame kun guyyaa ani mallatteesserraa kaasee waggaa tokkoof kan hojjetudha.

YAADANNOO: Tokkoo tokkoo sararaa ilaaluu fi mallatteessuu kee mirkaneeffadhu.

fayyaa sammuu

saalqunnamtii fi/ykn miidhaa qaamaa

yaaddoo alkoolii fi qoricha sammuu hadoochu

jeequmsa maatii

SIGNATURE OF APPLICANT

MALLATTOO IYYAATAA

DATE

GUY YAA

Section 2: Completed by LD/CPA Staff

Kutaa 2: Hojjetoota LD/CPA tiin kan guutamu

LICENSOR NAME

MAQAA ISA HEEYYAMAA

LICENSING DIVISION OFFICE MAILING ADDRESS AND FAX NUMBER

WAAJJIRA KUTAA HEEYYAMAA TEESSOON POOSTAA FI LAKKOOFSA FAKSII

Section 3: Completed by Medical Provider. Return to local Licensing Division office listed in Section 2.

Kutaa 3: Dhiyeessaa Fayyaatiin kan Guutame. Gara Qajeelcha Hayyamaa naannoo kutaa 2 keessatti tarreeffameetti deebi'i.

DATE OF MOST RECENT PHYSICAL EXAMINATION (**MUST BE WITHIN 12 MONTHS OF APPLICATION**)

GUY YAA QORANNOO QAAMAA HUNDA CAALAA DHIYEENYA GAGGEEFFAME (**ERGA IYYATA KANAATII JI'OOTAA 12 KEESSA TA'UU QABA**)

DATE FIRST SEEN BY PROVIDER

GUY YAA JALQABA DHIYEESSAATIIN ILAALAME

<p>CHRONIC / FREQUENT MEDICAL ISSUES (INCLUDING SIGNIFICANT PAST MEDICAL HISTORY) DHIMMOOTA WALLAANSA FAYYAARAA / IRRATTI ARGAMAN (SEENAA YAALAA DARBEE GUDDAA TA'E DABALATEE)</p>		
<p>CURRENT MEDICAL DIAGNOSIS QORANNOO FAYYAA KAN AMMAA</p>		
<p>CURRENT MEDICATIONS: PLEASE STATE THE PURPOSE OF THE MEDICATION, ANTICIPATED SIDE EFFECTS AND CONCERNS IF THE MEDICATION IS NOT TAKEN, AND HOW IT AFFECTS DAILY FUNCTIONING WALLAANSA FAYYAA KAN AMMAA: KAAYYOO WALLAANSA FAYYAA KANA, MIIDHAA MADDEE EEGAMUUFU WALLAANSI FAYYAA KUN YOO FUDHATAMUU BAATE YAADDOOWWAN JIRAN, AKKASUMAS AKKAMITTI AKKA HOJII GUYUU MIIDHU IBSI MAALOO</p>		
<p>PROGNOSIS TILMAAMA</p>		
<p>PLEASE DESCRIBE HOW ANY MEDICAL CONDITION AFFECTS THE CARE OF ADDITIONAL CHILDREN AKKAMITTI HAALLI FAYYAA KAMIYYU KUNUUNSA DAA'IMMANII DABALATAA AKKA MIIDHU IBSI MAALOO</p>		
<p>COMMENTS/ IMPRESSIONS: IS THE APPLICANT CAPABLE OF CARING FOR AN ADDITIONAL CHILD OR CHILDREN? YAADAWWAN/ILAALCHAWWAN: IYATAAN DAA'IMA YKN DAA'IMMAN DABALATAA KUNUUNSUUF NI DANDA'AA?</p>		
<p>SPECIALIST REFERRED TO (IF APPLICABLE) OGEESSOTA IRRATTI EERGAMU (YOO IRRRA JIRU)</p>		
<p>FAX NUMBER OF SPECIALIST (IF APPLICABLE) LAKKOOFSA FAKSII OGEESSOTA (YOO IRRRA JIRU)</p>		
<p>REASON FOR REFERRAL (IF APPLICABLE) SABABA IRRRA JIRU (YOO IRRRA JIRU)</p>		
<p>MEDICAL PROVIDER SIGNATURE MALLATTOO DHIYEESAA FAYYAA</p>		
<p>MEDICAL PROVIDER NAME MAQAA DHIHEESSAA WALLAANSA FAYYAA</p>	<p>SIGNATURE MALLATTOO</p>	<p>DATE GUYUAA</p>