Hope House

a Division of Resources for Human Development, Inc.

3606 Hecktown Road, Bethlehem, PA 18020

Phone (610) 882-2008 Fax (610) 882-2009

MEDICAL CLEARANCE

I, _____, certify that on_____, I evaluated
Name of Physician *Date*

_____ and I affirm that no medical conditions are present
Name of Consumer

which preclude living in a group home-setting (no nursing staff available 24-hours/day).

Is the consumer in need for on-going medical follow-up? Yes / No
(circle one)

⇨ If YES, for what medical conditions?

_____

_____

_____ _____
Name of Medical Professional (print) *Date*

_____
Signature of Medical Professional