

**MEDICAL CERTIFICATION
For Prospective Adoptive Parent**

Family name, first name, middle name: _____

Date and place of birth: _____

Place of permanent residence (address): _____

TO BE COMPLETED BY CERTIFYING PHYSICIAN

I certify that the following are correct and accurate results of the following medical examinations:

Dermatologist (skin diseases) _____
(diagnosis, ICD-10 code) (date)

Gynecologist/Proctologist (sexually transmitted diseases) _____
(diagnosis, ICD-10 code) (date)

Psychiatrist (psychological/mental diseases) _____
(diagnosis, ICD-10 code) (date)

Phthisiologist(TB specialist) _____
(diagnosis, ICD-10 code) (date)

Physician (General practitioner) _____
(diagnosis, ICD-10 code) (date)

Narcologist (drug/alcohol abuse) _____
(diagnosis, ICD-10 code) (date)

Wassermann reaction (syphilis test) _____
(date, result)

HIV test _____
(date, result)

Final Conclusion _____

Doctor _____ (Printed name) _____ (License # - if available) _____ (Signature)

Clinic's or doctor's
Seal (if available) _____ (Date)

TO BE COMPLETED BY NOTARY PUBLIC:

Subscribed and sworn to before me this _____ day

_____.

(Signature of Notary Public)

(NOTARY SEAL and NAME STAMP)