

## Provider Health Assessment

### Certification of Provider's Ability to Provide Assistance

|         |
|---------|
| Name    |
| Address |

I. Capability to provide assistance to others:  Good  Fair  Poor

Limitations (if any): \_\_\_\_\_  
\_\_\_\_\_

II. Physical health:  Good  Fair  Poor

Limitations (if any): \_\_\_\_\_  
\_\_\_\_\_

III. Emotional stability:  Good  Fair  Poor

Limitations (if any): \_\_\_\_\_  
\_\_\_\_\_

IV. Is the applicant free from communicable diseases?  Yes  No

If no, explain: \_\_\_\_\_  
\_\_\_\_\_

I certify that this individual is physically and emotionally capable of providing assistance to another individual who may have physical or emotional limitations.

|  |      |
|--|------|
| Signature of Physician, Advanced Registered Nurse Practitioner, or<br>Physician Assistant Working Under the Direction of a Physician | Date |
|--|------|