

Main Office:
3963 Three Mile Road
Traverse City, MI 49686

Satellite Office:
2240 Mitchell Park, Unit A
Petoskey, MI 49770

Satellite Office:
1640 Marty Paul
Cadillac, MI 49601

(231) 947-3780
(800) 632-7334
Fax: (231) 947-4935

(231) 347-9070
(800) 443-5518
Fax: (231) 347-3664

(231) 775-9781
(800) 443-2297
Fax: (231) 775-1448



Dear Health Care Provider

A Physical and TB test are requested by NMCAA – Northwest Michigan Community Action Agency

For this employee: _____

The Maximum that NMCAA will be responsible for is the following.

\$110 Employment Physical

\$ 40 for TB Test

Please send Invoice to:

NMCAA

Attn: Kim Aultman

3241 Racquet Club Dr.

Suite A

Traverse City, MI 49684

Thank You

Human Resources

Julie McNally

jmcnally@nmcaa.net



northwest michigan community action agency

www.nmcaa.net

a community action partnership

MEDICAL CLEARANCE REQUEST – CHILD CARE LICENSING

Michigan Department of Licensing and Regulatory Affairs

Child Care Licensing Bureau

APPLICANT/LICENSEE INFORMATION

Facility/Home Name		License Number	
Facility/Home Address (Street Number and Name)	City	State	Zip Code

PLEASE
MAIL TO



NMCAA – Program Support
3963 Three Mile Rd.
Traverse City, MI 49686

License Application Type

Child Care (Less Than 24-Hour Care)

PATIENT INFORMATION (To be Completed by Patient) (Please Print or Type)

Name (Last, First, Middle, Jr., II, etc.)	Date of Birth	Telephone Number	
Address (Street Number and Name)	City	State	Zip Code

RELEASE OF INFORMATION (To be Completed by Patient)

I authorize the release of medical information concerning me to the home listed above and to the Michigan Department of Licensing and Regulatory Affairs, Child Care Licensing Bureau, for the purpose of determining my suitability to provide or be associated with the care of children.	Date
	Patient's Signature
	Physician's Name (Please PRINT or TYPE)

MEDICAL INFORMATION (To be Completed by Physician)

<ul style="list-style-type: none">• This individual is, or will be, caring for children in a child care setting and may be solely responsible for children birth to age 17.• It is necessary to establish that those providing care are in such physical and mental condition and health as not to adversely affect the health or safety of a child and the quality and manner of his/her care.• To assist us in this determination, you are being asked to answer the following.			
Has this Person Been Tested for T.B.? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes	Date Tested (Required Only One Time)	Test Type <input type="checkbox"/> Skin Test <input type="checkbox"/> X-Ray	Results <input type="checkbox"/> Positive (Explain in Comments) <input type="checkbox"/> Negative
How would you describe the patient's general physical/mental condition and health? (Use Comments section for explanations) <input type="checkbox"/> No physical/mental condition or health problem exists that would limit the ability to provide independent care of children (birth to age 17) in a child care setting. <input type="checkbox"/> Physical/mental condition or health problem exists which would affect the ability to provide independent care of children (birth to age 17) in a child care setting, with or without reasonable accommodation. Explain in comments if reasonable accommodation may be needed.			
Comments (Please use back of this form if additional space is needed.)			
Would you like to be contacted by the licensing consultant regarding your recommendation? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Physician's Signature	Signature Date	Telephone Number	Examination Date
Address (Street Number and Name)	City	State	Zip Code
AUTHORITY: 1973 PA 116 RESPONSE: Voluntary PENALTY: Application for licensure may be denied.		LARA is an equal opportunity employer/program.	