

ARIZONA DEPARTMENT OF CHILD SAFETY
Office of Licensing and Regulation

HEALTH SELF-DISCLOSURE

NAME (Last, First, M.I.)	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH
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ADDRESS (No., Street, City, State, ZIP)

DATE OF MOST RECENT PHYSICAL EXAMINATION

Answer each of the following statements. The disclosure of a health condition will **NOT** automatically preclude licensure.

I have a History of:	Yes	No	I have a History of:	Yes	No	I have a History of:	Yes	No
Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Pain Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>

Explain any "yes" answers to the above and identify the treating physician/specialist.

Summary of past or present major illnesses, surgeries or treatments.

I have received services or treatment for a psychiatric disorder, emotional problem, or depression. Yes No If yes, explain.

I have received services or treatment for substance abuse. Yes No If yes, explain.

I regularly use the following medications.

Medication	Reason for Use	Medication	Reason for use

I certify that the information provided above is true, accurate, and complete. I understand that providing false information or the intentional misrepresentation of information on this Disclosure may result in the denial or revocation of my license/certification. The Health Self-Disclosure is to be used only for the purpose of evaluating me or a household member for licensure/certification.

SIGNATURE	DATE
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