APPENDICE D

CatholicCare

FAC OOHC PROGRAMS FORM: PROSPECTIVE FOSTER CARER RELEASE OF MEDICAL INFORMATION

Form number: OOHC 24/2
Issued: January 2015
Contact: Team Leader
Ph. (02) 8700-3333

Full name: ______________________________

Address: ______________________________

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I hereby give my authority for:

Name of Doctor: ______________________________

Address: ______________________________

To supply relevant medical information to CatholicCare to support my application to become a Foster Carer in the Families and Community stream.

Signature: ______________________________

Date: ______________________________