CSO-1232A (6-15)

ARIZONA DEPARTMENT OF CHILD SAFETY
Office of Licensing and Regulation

HEALTH SELF-DISCLOSURE

NAME *(Last, First, M.I.)*	GENDER ☐ Male ☐ Female	DATE OF BIRTH

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		Yes	No		Yes	No
Alcohol Abuse	☐	☐	Diabetes	☐	☐	High Blood Pressure	☐	☐
Asthma/Respiratory Problems	☐	☐	Drug Abuse	☐	☐	HIV/AIDS	☐	☐
Autoimmune Disease	☐	☐	Epilepsy	☐	☐	Mental Illness	☐	☐
Cancer	☐	☐	Heart Disease	☐	☐	Tuberculosis	☐	☐
Chronic Pain Disorder	☐	☐	Hepatitis	☐	☐	Other:	☐	☐

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

See reverse for EOE/ADA/GINA/LEP disclosures

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