ATTENDING PHYSICIAN MEDICAL CLEARANCE/STATEMENT FOR

MEDICAL CONSENT BY ALTA CALIFORNIA REGIONAL CENTER

| has no legally authorized consenter or I was unable to contact the legally authorized consenter after a reasonable time period. | l, | , (requester), have attempted to contact the legally |
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| after a reasonable time period. Dated: | authorized consenter for | 's procedure. The client either |
| Dated: | has no legally authorized consenter or | I was unable to contact the legally authorized consenter |
| (Signature of Requester) I, | | after a reasonable time period. |
| (Signature of Requester) I, | | |
| (Signature of Requester) I, | Dated: | |
| I, , am the attending physician/surgeon/dentist for , who is a client of Alta California Regional Center. I have examined this patient, and I recommend that he/she undergo the following necessary medical/surgical/dental procedure: I declare that, in my opinion, the above recommended procedure is necessary for the well-being of this patient and the patient is receiving no medication or form of treatment that would contraindicate the provision of this requested procedure. I request that Alta California Regional Center provide consent for the procedure, pursuant to Welfare & Institutions Code section 4655, which authorizes the designee of the Regional Center Director to give medical consent when there is no parent, guardian or conservator legally authorized to do so, or when a developmentally disabled person's person, guardian, or conservator does not respond within a reasonable time to the request of the Director or his designee for the granting or denying of consent for such treatment. Dated: | | (Signature of Requester) |
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| Dated: | Center, hereby provide consent for the physician/surgeon/dentist of | |

(Signature of ACRC Director's Designee)