ATTENDING PHYSICIAN
MEDICAL CLEARANCE/STATEMENT
FOR
MEDICAL CONSENT BY ALTA CALIFORNIA REGIONAL CENTER

I, _____ , (requester), have attempted to contact the legally authorized consenter for _____ 's procedure. The client either has no legally authorized consenter or I was unable to contact the legally authorized consenter _____ after a reasonable time period.

Dated: _____ _____

(Signature of Requester)

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 attending/physician/surgeon/dentist)

I, _____ , the Designee of the Director of Alta California Regional Center, hereby provide consent for the above recommendation(s) by the attending physician/surgeon/dentist of _____ as authorized by Welfare & Institutions Code Section 4655.

Dated: _____ _____

(Signature of ACRC Director's Designee)