



## RECOMMENDATION LETTER

DATE: \_\_\_\_\_

LICENSING COUNSELOR: \_\_\_\_\_

AGENCY:  LUTHERAN  FPS  FBCH

**FAMILY NAME:** \_\_\_\_\_

\_\_\_\_\_ At this time we **DO** recommend licensure. The family HAS satisfied the requirements outlined in 65C-13.

\_\_\_\_\_ At this time we **DO NOT** recommend licensure. The family **HAS NOT** satisfied the requirements outlined in 65C-13.

ADOPTION ONLY:  YES  NO

FOSTER CARE:  Regular  Child Spec  ICPC  
 Foster/Adopt  TFC  Medical

RECOMMENDED CAPACITY: \_\_\_\_\_

RECOMMENDED AGE RANGE: \_\_\_\_\_ - \_\_\_\_\_

GENDER:  MALE  FEMALE  EITHER  BOTH

SPECIFIC LIMITATIONS: \_\_\_\_\_

\_\_\_\_\_

COMMENTS: \_\_\_\_\_

\_\_\_\_\_

Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_