



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: _____