GOVERNMENT OF GUAM
DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
Division of Environmental Health, Health Certificate Program
Division of Public Health, Communicable Disease Control Program

Health Certificate Clearance Application

THIS BOX MUST BE FILLED IN BEFORE SHOWING THIS FORM TO THE DOCTOR

Applicant's Name: ______________________________
Last First MI

Birth Date: __/__/____ Social Security # _____-____-_____ Sex: ☐ Male ☐ Female Home Phone: __________

Mailing Address: ______________________________

Residential Address: ______________________________

Name of Business Applied For: ______________________ Location: __________

Job Title Applied For: ______________________ Ethnicity (Country of Origin): __________

I certify that the information provided above is true and accurate to the best of my knowledge:

SIGNATURE: ______________________ Date: __________

NOTE TO APPLICANT: Please have your PHOTO IDENTIFICATION (passport, drivers license, authorization to work (for alien workers or other photo I.D.) with you when you return to the Department of Public Health and Social Services with this form.

TYPE OF APPLICATION

NOTE TO PHYSICIAN: The above named person is applying for DPH&SS Health Certificate in the occupation category checked below. Occupation category health screening requirement are as indicated.

☐ NEW APPLICANT

☐ EATING & DRINKING/FOOD ESTABLISHMENT:
- PPD skin test for TB - if positive perform chest x-ray

☐ COSMETOLOGY:
- PPD skin test for TB - if positive perform chest x-ray
- Professional License

☐ MASSAGE: (Two photographs required)
- PPD skin test for TB - if positive perform chest x-ray
- Physical Examination
- Blood test for Syphilis and HIV antibody
- Culture for Gonorrhea and Chlamydia

☐ TATTOO:
- PPD skin test for TB – if positive perform chest x-ray
- Physical Examination
- Blood test for Syphilis and HIV antibody

☐ INSTITUTIONAL (Nursing Home, Adult Care, Child Care, Correctional Facility):
- PPD Skin test for TB – if positive perform chest x-ray
- Physical Examination

☐ LAUNDRY/DRY CLEANING:
- PPD Skin test for TB – if positive perform chest x-ray
- Physical Examination

☐ THERAPEUTIC MASSAGE: (Two photographs required)
- PPD Skin test for TB – if positive perform chest x-ray
- Physical Examination
- Professional License

☐ RENEWAL APPLICANT

☐ COSMETOLOGY:
- PPD skin test for TB - if positive perform chest x-ray
- Professional License

☐ MASSAGE: (Two photographs required)
- PPD Skin test for TB – if positive perform chest x-ray
- Physical Examination
- Blood test for Syphilis and HIV antibody
- Culture for Gonorrhea and Chlamydia

☐ TATTOO:
- PPD Skin test for TB – if positive perform chest x-ray
- Physical Examination
- Blood test for Syphilis and HIV antibody

☐ INSTITUTIONAL (Nursing Home, Adult Care, Child Care, Correctional Facility):
- PPD Skin test for TB – if positive perform chest x-ray
- Physical Examination

☐ LAUNDRY/DRY CLEANING:
- PPD Skin test for TB – if positive perform chest x-ray
- Physical Examination

☐ THERAPEUTIC MASSAGE: (Two photographs required)
- PPD Skin test for TB – if positive perform chest x-ray
- Physical Examination
- Professional License

PHYSICIAN'S CERTIFICATION ON REVERSE SIDE

PHYSICIAN'S CERTIFICATION

NOTE TO ALL HEALTH CARE PROVIDERS: Please review the following instructions before completing this form.

PPD TEST RESULTS: Report the results of PPD's by giving the date the PPD was given, the date read, and the measurement in millimeters (mm).

Section A: This section is to be completed only if the applicant is free of communicable diseases, including those for which screening is specified.

Section B: This section is to be completed only if the applicant is not free of communicable diseases, including those for which screening is specifically indicated. Applicants with positive PPD skin tests must be referred by their physician to their reference x-ray facility to have a routine chest x-ray performed to screen for active tuberculosis. This x-ray must be read and interpreted by a licensed radiologist and a written report prepared for the physician.

COMMUNICABLE DISEASE CONTROL (CDC) CERTIFICATION: CDC certification is to be signed ONLY by the CDC tuberculosis Program Coordinator upon completion of all the reporting requirements and after the CDC physician's medical evaluation certifies the applicant has completed / or is currently under treatment and has been certified as non-contagious.

WARNING: THIS CLEARANCE IS NOT VALID UNLESS THE PRINTED NAME AND SIGNATURE OF THE PHYSICIAN / AUTHORIZED PERSON (INCLUDING TITLE) ARE PRESENT IN SECTION "A" OR "B" ALONG WITH THE PHYSICIAN'S / AUTHORIZED PERSONS STAMP AND THE REQUIRED MEDICAL INFORMATION.

PPD TEST RESULTS: Date Given: ____________________, Date Read:__________________, Reading: ____________(mm)

PLEAS CHECK AND COMPLETE EITHER SECTION "A" OR "B" AS APPROPRIATE

"I have performed the health screen tests indicated on the front of this form and find the applicant:

A

☐ is free of the communicable diseases for which screening is indicated above for the occupation in which the applicant desires employment

____

Physician's or Other AUTHORIZED Name (Print or Stamp)

____

If not Physician, Title (Print or Stamp)

____

Signature Date

This Applicant should go directly to the DIVISION OF ENVIRONMENTAL HEALTH at the Department of Public Health and Social Services in Mangilao to continue processing.

COMMUNICABLE DISEASE CONTROL CERTIFICATION

FOR COLUMN "B" TO THE RIGHT:

The applicant ☐may, ☐ may not

Be employed in the occupation indicated above as of this

Date__________________

____

Signature: DPH&SS, CDC Certifying Official

B

☐ is **NOT** free of the communicable diseases for which screening is indicated above for the occupation in which the applicant desires employment

Attached are the copies of the following indicated documents:

- ☐ Physical Examination (Health Screen) Form
- ☐ A written report of laboratory test results.
- ☐ A copy of the official Radiological Report.
- ☐ Other (Specify) _______________________

____

Physician's or Other AUTHORIZED Name (Print or Stamp)

____

If not Physician, Title (Print or Stamp)

____

Signature Date

This Applicant should go directly to the COMMUNICABLE DISEASE CONTROL PROGRAM, ROOM 118 at the Department of Public Health and Social Services in Mangilao to continue processing.

FOR DEH USE ONLY

Received by:_______________________________

Date: