

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)

PLEASE 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: _____

POSITIVE REACTOR STATUS REPORT

MUST BE COMPLETED AND SUBMITTED WITH TB
EVALUATION CLEARANCE FORM ONLY IF THE PPD SKIN TEST IS POSITIVE

NAME _____ DOB _____ - _____ - _____
ADDRESS _____ ETHNICITY _____
PHONE(Home/Work): _____ / _____

1. PPD Test: Date Given: _____ Date Recd: _____ Results: _____ mms
2. Chest X-Ray: Date _____ Normal _____ Abnormal _____
** NOTE: Radiological Interpretation by Licensed Radiologist Must be attached.*
3. INH Preventive Therapy Offered: Yes _____ No _____
4. Patient is currently on INH Preventive Therapy at my clinic.
Yes _____ No _____ Date Preventive Therapy Started: _____
5. If not on INH Preventive Therapy, please state reason:
____ a. Patient refuses INH Preventive Therapy offered.
____ b. Patient is over 35 years of age with no risk factor.
____ c. Other (Specify) _____
6. Patient cleared for work/School: Yes _____ No _____
7. Patient referred to DPHSS Communicable Disease Control Clinic for possible INH Preventive Therapy.
Yes _____ No _____
8. Patient referred to DPHSS Communicable Disease Control Clinic for possible active TB.
Yes _____ No _____
9. Comments: _____

Physicians' Signature

Date

Name of Physician/Clinic (print)