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

PLEASE COMPLETE BOX BELOW BEFORE PRESENTING THIS FORM TO YOUR HEALTHCARE PROVIDER

Applicant's Name: ______________________________ **Citizenship:** ____________
Last First Middle

Birth Date: ____/____/______ (Mo.) (Day) (Year) **Social Security #** ______ - _____ - _______ **Sex:** ☐ **Male** ☐ **Female**

Marital Status: ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Widowed** **Ethnicity/Nationality:** ____________

Contact Number: **(Work)** ____________ **(Home)** ____________ **(Cell)** ____________

Mailing Address: ______________________________

Residential Address: ______________________________

Place of Employment: ______________________ **Location (Village):** ____________

Job Title: ______________________________

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

SIGNATURE: ______________________ **Date:** ____________

NOTE TO APPLICANT: A valid photo I.D. (i.e. passport, driver's license, authorization to work for alien workers, or other valid photo I.D.) must be presented when submitting this form to the department.

TYPE OF APPLICATION

NOTE TO HEALTHCARE PRACTITIONER: The above-named person is applying for DPH&SS Health Certificate in the occupation category checked below.

☐ NEW APPLICANT

☐ **FOOD FACILITY (GFC):**
- PPD skin test for TB within 6 months of applying – if ***POSITIVE***, perform chest x-ray and obtain clearance from CDC office, Room 118.

☐ **COSMETOLOGY:**
- PPD skin test for TB within 6 months of applying – if ***POSITIVE***, perform chest x-ray and obtain clearance from CDC office, Room 118.
- Certification of Examination
- Professional License

☐ **COSMETOLOGY STUDENT:**
- PPD skin test for TB within 6 months of applying – if ***POSITIVE***, perform chest x-ray and obtain clearance from CDC office, Room 118.
- Certification of Examination
- Letter of enrollment from certified cosmetology school

☐ **COSMETOLOGY HELPER ONLY:**
- PPD skin test for TB within 6 months of applying – if ***POSITIVE***, perform chest x-ray and obtain clearance from CDC office, Room 118.

☐ **TATTOO:**
- PPD skin test for TB within 6 months of applying – if ***POSITIVE***, perform chest x-ray and obtain clearance from CDC office, Room 118.
- Certification of Examination

☐ **INSTITUTIONAL (Nursing Home, Adult Care, Child Care, Correctional Facility):**
- PPD skin test for TB within 6 months of applying – if ***POSITIVE***, perform chest x-ray and obtain clearance from CDC office, Room 118.
- Physician's Certification of Examination

☐ **LAUNDRY/DRY CLEANING:**
- PPD skin test for TB within 6 months of applying – if ***POSITIVE***, perform chest x-ray and obtain clearance from CDC office, Room 118.
- Physician's Certification of Examination

☐ **THERAPEUTIC MASSAGE:**
- Two current passport sized photographs
- PPD skin test for TB within 6 months of applying – if ***POSITIVE***, perform chest x-ray and obtain clearance from CDC office, Room 118.
- Certification of Examination
- Professional License

☐ **THERAPEUTIC MASSAGE HELPER ONLY:**
- PPD skin test for TB within 6 months of applying – if ***POSITIVE***, perform chest x-ray and obtain clearance from CDC office, Room 118.

☐ RENEWAL APPLICANT

☐ **FOOD FACILITY (GFC):**
- Do not use this form, please use the *RENEWAL of Eating & Drinking and/or Food Establishments* form

☐ **COSMETOLOGY:**
- PPD skin test for TB within 6 months of applying – if ***POSITIVE***, perform chest x-ray and obtain clearance from CDC office, Room 118.
- Certification of Examination
- Professional License

☐ **COSMETOLOGY STUDENT:**
- PPD skin test for TB within 6 months of applying – if ***POSITIVE***, perform chest x-ray and obtain clearance from CDC office, Room 118.
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HEALTHCARE PROVIDER CERTIFICATION ON REVERSE SIDE

HEALTHCARE PROVIDER CERTIFICATION

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

PPD TEST RESULTS: Report the result of PPD skin test 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 of the department upon completion of all the reporting requirements and after the CDC physician's medical evaluation certifies that 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 PERSON'S STAMP AND THE REQUIRED MEDICAL INFORMATION.

Applicant's Name: ____

PPD TEST RESULT: 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 and Stamp)

____
If not Physician, Title (Print and 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 Officer

B

☐ is **NOT** free of the communicable disease for which screening is indicated above for the occupation in which the application 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 and Stamp)

____
If not Physician, Title (Print and Stamp)

____
Signature Date

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

FOR DEH USE ONLY:

Received by: ______________________________

Date: ______________________________

TUBERCULOSIS (TB) EVALUATION FORM

PLEASE SUBMIT FOR CLEARANCE REQUEST FOR PATIENTS HAVING POSITIVE TB INFECTION

NAME ______________________ **DOB:** ______________
HOME ADDRESS: ______________________ **ETHNICITY:** ______________
MAILING ADDRESS: ______________________ **PHONE NUMBERS:** ______________
(Home/Work/Mobile)

PPD SKIN TEST	Date given:___________ Date read: ___________ Result:_____________ Reading: ________mm
IGRA TEST	Date given:___________ Test Type: ____________ Result: ___________________________

Has the patient been exposed to active TB in the last (2) years? *Yes* *No*

SYMPTOMS ≥ 2 WEEKS	**YES**	**NO**		**DOES THE PATIENT HAVE A HISTORY OF:**
Cough				Cancer Yes No Type: ____________________
Fever				Hepatitis Yes No
Weight loss				Kidney Disease Yes No On dialysis? Yes No
Night sweats				Rheumatoid Arthritis (Joint Pain) Yes No
Fatigue				HIV/AIDS Yes No On medications? Yes No
Chest pain				
Shortness of breath				Other/Note: ____________________________________
Hoarseness				

If response is "yes" to any of the symptoms or CXR is abnormal, patient will need a repeat (2) view CXR or follow the Radiologist' recommendations before referral to Public Health for clearance*

Chest X-ray
(copy of report **MUST** be attached) Date of CXR: ___________ Normal / Abnormal
Comments: ____

REPEAT CXR
(if applicable, copy of report **MUST** be attached) Date of CXR: ___________ Normal / Abnormal
Comments: ____

NOTE: If active TB is suspected, refer by call or email to the Tuberculosis/Hansen's Disease Control Program

LTBI TREATMENT: 3HP INH RIF Other: _________________________
Date Started:_______________Date Completed:_________________
Refused Date Refused __________Reason for refusing:___________________________
Adverse reactions to LTBI therapy? ***Yes*** ***No***

By signing this form, I,____________________________________(Name of licensed provider (MD/NP/PA)), am certifying that I have ruled out active TB and the patient is cleared for work/school.

NAME OF CLINIC	**PHYSICIAN SIGNATURE/STAMP**	***Date (valid 90 days)***

Revised and effective: August 01, 2020

DEPARTMENT OF PUBLIC HEALTH & SOCIAL SERVICES
BUREAU OF COMMUNICABLE DISEASE CONTROL
TUBERCULOSIS/HANSEN'S DISEASE CONTROL PROGRAM
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