



**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: ____/____/____ **Social Security #** ____ - ____ - ____ **Sex:** Male Female
(Mo.) (Day) (Year)

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.
 - 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
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 - 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.

**LATENT TUBERCULOSIS INFECTION (LTBI)
QUESTIONNAIRE**

**PLEASE SUBMIT FOR CLEARANCE REQUEST FOR PATIENTS HAVING POSITIVE TB
SKIN TEST**

NAME		DOB _____/_____/_____
ADDRESS		
ETHNICITY		PHONE NUMBERS: (HOME/WORK/MOBILE)

PPD SKIN TEST	Date given:	Date read:	Results: _____ mm
Chest X-Ray <small>(Copy of report MUST Be Attached)</small>	Date of CXR exam:	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Comments: _____ _____
LTBI Treatment	Date treatment started:	Date completed:	<input type="checkbox"/> No h/o treatment
	Adverse reactions to LTBI therapy? <input type="checkbox"/> YES <input type="checkbox"/> NO		Patient declined therapy? <input type="checkbox"/> YES <input type="checkbox"/> NO

Have you been exposed to active TB? <input type="checkbox"/> YES <input type="checkbox"/> NO			
SYMPTOMS	YES	NO	<i>If response is "yes" to any of the symptoms, patient will need a repeat 2 view CXR before referral to Public Health for clearance.</i> Please include findings from repeat CXR (Copy of report <u>MUST</u> be attached): <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Cough			
Fever			
Weight loss			
Night sweats			
Fatigue			
Chest pain			
Shortness of breath			
Hoarseness			

Patient is cleared for work/school	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Patient is referred to the Department of Public Health Communicable Disease Clinic for possible active tuberculosis (All required documents <u>MUST</u> accompany referral).	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Physician Signature/Stamp

Name of Physician/Clinic

Date (Valid 90 days)

DEPARTMENT OF PUBLIC HEALTH & SOCIAL SERVICES
BUREAU OF COMMUNICABLE DISEASE CONTROL
TUBERCULOSIS/HANSEN'S DISEASE CONTROL PROGRAM
123 Chalan Kareta, Mangilao, Guam 96913
671-735-7157/7131/7120/7145