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:** _____

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

☐ **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
- Certification of Examination
- Professional License

☐ **MASSAGE:**
- Two current passport size photographs
- PPD skin test for TB – if positive, perform chest x-ray
- Certification of Examination

☐ **TATTOO:**
- PPD skin test for TB – if positive, perform chest x-ray
- Certification of Examination

☐ **INSTITUTIONAL (Nursing Home, Adult Care, Child Care, Correctional Facility):**
- PPD skin test for TB – if positive, perform chest x-ray
- Physician's Certification of Examination

☐ **LAUNDRY/DRY CLEANING:**
- PPD skin test for TB – if positive, perform chest x-ray
- Physician's Certification of Examination

☐ **THERAPEUTIC MASSAGE:**
- Two current passport size photographs
- PPD skin test for TB – if positive, perform chest x-ray
- Certification of Examination
- Professional License

☐ RENEWAL APPLICANT

☐ **COSMETOLOGY:**
- PPD skin test for TB – if positive, perform chest x-ray
- Certification of Examination
- Professional License

☐ **MASSAGE:**
- Two current passport size photographs
- PPD skin test for TB – if positive, perform chest x-ray
- Certification of Examination

☐ **TATTOO:**
- PPD skin test for TB – if positive, perform chest x-ray
- Certification of Examination

☐ **INSTITUTIONAL (Nursing Home, Adult Care, Child Care, Correctional Facility):**
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- Professional License

HEALTHCARE PROVIDER CERTIFICATION ON REVERSE SIDE →

DEH-001 (Rev. 10/6/10)

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.

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 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 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 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 Dept. of Public Health and Social Services in Mangilao to continue Processing.

FOR DEH USE ONLY:

Received by: _____

Date: _____

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 (Copy of report **MUST** Be Attached)	Date of CXR exam:	☐ Normal ☐ Abnormal	Comments: _____ _____
LTBI Treatment	Date treatment started:	Date completed:	☐ No h/o treatment
	Adverse reactions to LTBI therapy? ☐ YES ☐ NO		Patient declined therapy? ☐ YES ☐ NO

Have you been exposed to active TB? ☐ YES ☐ NO

SYMPTOMS	YES	NO
Cough		
Fever		
Weight loss		
Night sweats		
Fatigue		
Chest pain		
Shortness of breath		
Hoarseness		

If response is "yes" to any of the symptoms, patient will need a repeat 2 view CXR before referral to Public Health for clearance.

Please include findings from repeat CXR (Copy of report **MUST** be attached**):**

☐ Normal
☐ Abnormal

Patient is cleared for work/school	☐ Yes	☐ No
Patient is referred to the Department of Public Health Communicable Disease Clinic for possible active tuberculosis **(All required documents MUST accompany referral**).	☐ Yes	☐ 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

Revised and effective: September 10, 2015

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
DIVISION OF ENVIRONMENTAL HEALTH

MASSAGE PARLORS
CERTIFICATION OF HEALTH EXAMINATION

APPLICANT: ***Please complete and submit this form if applying for Health Certificate to work at a Massage Parlor (Title 10 GCA, Chapters 22 and 27). NOTE: Only forms with the original signature of the healthcare provider will be accepted. Stamped or digital signatures will NOT be accepted.***

Name: _____ Sex: _____ Citizenship: _____
Last, First MI

Date of Birth: ____/____/_____ Place of Birth: _____ Ethnicity/Nationality: _____

Place of Employment: _____ Location: _____

Healthcare Provider: ***Please complete the portion below and return to above applicant for submission to the Department of Public Health and Social Services.***

Based on my examination of the above person, I certify that the individual:

1. Has been tested for tuberculosis within the past 6 months of this date and the result was negative, OR result was positive but further test(s) revealed that the individual is not infectious.
2. Has been tested and is free from sexually transmitted diseases, including HIV.
3. Is currently free of any communicable disease that can be easily transmitted to another individual at the above person's workplace during his/her usual course of activities.

For Official Use Only

_____
NAME OF HEALTHCARE PROVIDER

_____
SIGNATURE

_____
CLINIC OR HOSPITAL

Date: _____