



**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**

**RENEWAL 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.

- 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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  - 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.

# 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	B
<input type="checkbox"/> is free of the communicable diseases for which screening is indicated above for the occupation in which the applicant desires employment.	<input type="checkbox"/> is <b><u>NOT</u></b> free of the communicable disease for which screening is indicated above for the occupation in which the application desires employment.
_____ Physician's or other <u>Authorized</u> Name (Print and Stamp)	Attached are the copies of the following indicated documents: <input type="checkbox"/> Physical Examination (Health Screen) Form <input type="checkbox"/> A written report of laboratory test results. <input type="checkbox"/> A copy of the official Radiological Report. <input type="checkbox"/> Other (Specify) _____
_____ If not Physician, Title (Print and Stamp)	_____ Physician's or Other <u>AUTHORIZED</u> Name (Print and Stamp)
_____ Signature <span style="float: right;">Date</span>	_____ If not Physician, Title (Print and Stamp)
This Applicant should go directly to the <u>DIVISION OF ENVIRONMENTAL HEALTH</u> at the Department of Public Health and Social Services in Mangilao to continue processing.	_____ Signature <span style="float: right;">Date</span>
<b>COMMUNICABLE DISEASE CONTROL CERTIFICATION</b> FOR COLUMN "B" TO THE RIGHT: The applicant <input type="checkbox"/> may <input type="checkbox"/> may not Be employed in the occupation indicated above as of this	This Applicant should go directly to the <u>COMMUNICABLE DISEASE CONTROL PROGRAM, ROOM 118,</u> at the Dept. of Public Health and Social Services in Mangilao to continue Processing.
Date: _____	<b>FOR DEH USE ONLY:</b> <b>Received by:</b> _____
_____ Signature: DPH&SS, CDC Certifying Officer	<b>Date:</b> _____

**LATENT TUBERCULOSIS INFECTION (LTBI)  
QUESTIONNAIRE**

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

<b>NAME</b>		<b>DOB</b> ____/____/____
<b>ADDRESS</b>		
<b>ETHNICITY</b>		<b>PHONE NUMBERS: (HOME/WORK/MOBILE)</b>

<b>PPD SKIN TEST</b>	Date given:	Date read:	Results: _____ mm
<b>Chest X-Ray</b> <small>(Copy of report <b>MUST</b> Be Attached)</small>	Date of CXR exam:	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Comments: _____ _____
<b>LTBI Treatment</b>	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			
<b>SYMPTOMS</b>	<b>YES</b>	<b>NO</b>	<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>  <b>Please include findings from repeat CXR (Copy of report <u>MUST</u> be attached):</b> <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 ( <b>All required documents <u>MUST</u> accompany referral</b> ).	<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



**DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES  
DIVISION OF ENVIRONMENTAL HEALTH**



**LAUNDRY AND DRY CLEANING  
PHYSICIAN'S CERTIFICATION OF EXAMINATION**

*Applicant: Please complete and submit this form if applying for Health Certificate to work at a Laundry or Dry Cleaning facility engaged in the sorting, folding, washing, starching, ironing, dyeing, or dry cleaning clothes, household linens, and other fabric articles (Title 10 GCA, Chapters 22 and 28). NOTE: Only forms with original signature of the physician 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. 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 PHYSICIAN**

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**CLINIC OR HOSPITAL**

Date: \_\_\_\_\_