



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

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

# 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> _____



# TUBERCULOSIS (TB) EVALUATION FORM

PLEASE SUBMIT FOR CLEARANCE REQUEST FOR PATIENTS HAVING POSITIVE TB INFECTION



<b>NAME</b>	_____	<b>DOB:</b>	_____
<b>HOME ADDRESS:</b>	_____	<b>ETHNICITY:</b>	_____
<b>MAILING ADDRESS:</b>	_____	<b>PHONE NUMBERS:</b>	_____
(Home/Work/Mobile)			

<b>PPD SKIN TEST</b>	Date given: _____	Date read: _____	Result: _____	Reading: _____ mm
<b>IGRA TEST</b>	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				Other/Note:	_____				
Shortness of breath									
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\***

<b>Chest X-ray</b>		
(copy of report <b>MUST</b> be attached)	Date of CXR: _____	Normal Abnormal
<b>REPEAT CXR</b>	Comments: _____	
(if applicable, copy of report <b>MUST</b> 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**

<b>LTBI TREATMENT:</b>	3HP	INH	RIF	Other: _____
	Date Started: _____		Date Completed: _____	
	Refused	Date Refused _____	Reason for refusing: _____	
<b>Adverse reactions to LTBI therapy?      Yes      No</b>				

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.

_____ <b>NAME OF CLINIC</b>	_____ <b>PHYSICIAN SIGNATURE/STAMP</b>	_____ <b>Date (valid 90 days)</b>
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