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.
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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 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 at the Dept. of Public Health and Social Services 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**
Cough		
Fever		
Weight loss		
Night sweats		
Fatigue		
Chest pain		
Shortness of breath		
Hoarseness		

DOES THE PATIENT HAVE A HISTORY OF:

Cancer ☐ Yes ☐ No Type: _____

Hepatitis ☐ Yes ☐ No

Kidney Disease ☐ Yes ☐ No On dialysis? ☐ Yes ☐ No

Rheumatoid Arthritis (Joint Pain) ☐ Yes ☐ No

HIV/AIDS ☐ Yes ☐ No On medications? ☐ Yes ☐ No

Other/Note: _____

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)***

DEPARTMENT OF PUBLIC HEALTH & SOCIAL SERVICES
BUREAU OF COMMUNICABLE DISEASE CONTROL
TUBERCULOSIS/HANSEN'S DISEASE CONTROL PROGRAM
520 West Santa Monica Avenue, Dededo, Guam 96929
Phone: (671) 687-4388 / Email: tb.program@dphss.guam.gov

Revised and effective: August 01, 2020

CLEAR FORM

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
DIVISION OF ENVIRONMENTAL HEALTH

INSTITUTIONAL FACILITY
PHYSICIAN'S CERTIFICATION OF EXAMINATION

APPLICANT: ***Please complete and submit this form if applying for Health Certificate to work at a Childcare facility, Nursing Home, Adult Care, Correctional Facility and other institutional facility (Title 10 GCA, Chapters 22 and 25). NOTE: Only forms with the 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 (STAMP)

Date: _____