



**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
  - 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.

# 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 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 and Stamp)

\_\_\_\_\_  
If not Physician, Title (Print and 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:** \_\_\_\_\_



# 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 $\geq$ 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's 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
Comments: _____	
<b>REPEAT CXR</b>	
(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.

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



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**

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