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.

_____
NAME OF PHYSICIAN

_____
SIGNATURE

_____
CLINIC OR HOSPITAL

For Official Use Only

Date: _____