

Public Health Statement of HIV Verification - HOPWA

Note: This form must be filled out by a physician, certified health care provider or a certified HIV testing site

Applicant's Name: _____

Social Security Number: _____

Physician or certified health care provider MUST complete:

I certify that _____ has tested positive for the

Human Immunodeficiency Virus on ____/____/____ (date).

Printed Name: _____

Signature: _____

License #: _____ (if applicable) State Issued _____

Date: _____

Telephone: (_____) _____

Fax: (_____) _____

Address: _____

City: _____ State: _____ Zip: _____

NOTES:
