Georgia Department of Public Health

Environmental Health Section
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Symptomatic with Vomiting or Diarrhea - Medical Documentation Verification Form

Physician	
Phone #	
Fax #	
Patient/Case #	
Symptomatic of (please circle all that apply)	Vomiting Diarrhea
Date of Diagnosed Symptom(s)	

Please provide a summary of tests performed (include dates of stool samples):

Date of stool specimen #1: _____

Date of stool specimen #2: _____

(Please initial if the statement has been confirmed)

_____ The Patient/Case # listed above symptom(s) is/are from a noninfectious condition(s)

Physician Signature: _____

Date: _____