Environmental Health Section

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https://dph.georgia.gov/environmental-health/food-service

Medical Documentation Verification Form - Shigella spp.	
Physician Name:	
Phone #	
Fax #	
Patient/Case #	
Diagnosis:	
Date of Diagnosis:	

Please provide a summary of medical treatment/tests (include dates of stool samples) that were performed:

Date of Stool specimen culture #1: ___________________

Date of stool specimen culture #2: ____________________

(Please initial if the below statement is accurate)

______ The above Patient/Case # is free of ***Shigella* spp.** infection based on test results showing 2 consecutive negative stool specimen cultures that were taken:

- Not earlier than 48 hours after discontinuance of antibiotics, and at least 24 hours apart.

Physician Signature: ____

Date: ____

Updated *4/14/26*