

**nontyphoidal *Salmonella* – Medical Documentation Verification Form**

<b>Physician</b>	
<b>Phone #</b>	
<b>Fax #</b>	
<b>Patient/Case #</b>	
<b>Diagnosis</b>	
<b>Date of Diagnosis</b>	

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

Date of stool specimen #1: \_\_\_\_\_

Date of stool specimen #2: \_\_\_\_\_

(Please initial below if the actions were taken)

\_\_\_\_\_ The Patient/Case# is free of a **nontyphoidal *Salmonella*** 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:** \_\_\_\_\_

