Georgia Department of Public Health

Environmental Health Section
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Salmonella *Typhi* – Medical Documentation Verification Form

Physician	
Phone #	
Fax #	
Patient/Case #	
Diagnosis	
Date of Diagnosis	

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

(Please initial below if the statement is accurate)

______ The above Patient/Case # is free from **Salmonella *Typhi*** infection.

Physician Signature: ______________________________________

Date: ____

We Protect Lives.