Georgia Department of Public Health

Environmental Health Section
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***Shigella* spp. –** Medical Documentation Verification Form

Physician	
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 statement below 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: _____