MEDICAL CERTIFICATION FORM
Please complete and fax to 804-864-8050. Call 855-362-0658 with any questions.

MEDICAL PROVIDER CONTACT INFORMATION

Date Form Completed:		
Client First Name:	Client Last Name:	Client Date of Birth:
Person Completing Form		
Phone Number for Person Completing Form		
Medical Provider Name		
Medical Practice Name		
Provider Phone Number	Provider Fax Number	

CLIENT MEDICAL INFORMATION

Current Disease Status ☐ **HIV Positive, not AIDS** ☐ **HIV Positive, AIDS status unknown** ☐ **CDC-defined AIDS**

Current CD4 Count	_____	Date of Current CD4 Count	____/____/_____
Current Viral Load	_____	Date of Current Viral Load	____/____/_____
Date of Last HIV Medical Care Visit	___/____/_____		

List Medications Prescribed for this Client (or attach a medication list). **Required if applying for ICAP.**

MEDICATION NAME	DOSAGE

I certify that I am treating the above named client for HIV and that all information provided in this form is accurate and complete to the best of my knowledge.

_____ _____

Signature of Authorized Personnel (Physician, Case Manager, etc.) Date Signed

HEALTH COVERAGE INFORMATION (OPTIONAL)

Have you used tobacco products in any form within the last 12 months?	☐ Yes	☐ No
If, Yes please provide the type, amount of tobacco used and frequency?		