**PROOF OF POSITIVITY FORM: RYAN WHITE PART B**

MUST be completed and signed by a clinician who has seen client in past.

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| **MEDICAL CLINICIAN CONTACT INFORMATION** |
| Applicant First Name:  | Applicant Last Name: |
| Applicant Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ | Person Completing Form: |
| Medical Clinician Name: | Clinician Phone Number: |
| Medical Practice Name: | Clinician Fax Number: |
| Medical Clinician’s License #: | Medical Clinician’s State of Licensure: |

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| **MEDICAL INFORMATION** |
| **1. When was the applicant’s last HIV medical care visit?**  | \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_ |
| **2. What is the applicant’s current HIV disease status?** |
| [ ]  HIV Positive, not AIDS  | [ ]  HIV Positive, AIDS status unknown  | [ ]  CDC-defined AIDS: Both HIV and AIDS diagnosis date(s) are required (even if the same date) |
| **3. HIV Diagnosis Date** | \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_  | **AIDS Diagnosis Date** | \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_ [ ]  N/A |
| **4. Provide most recent lab values AND regimen at time of labs in space provided.**Date drawn on lab values must be within the last 12 months. Check the “results pending” space if most recent lab results are pending. |
| Date Drawn | ResultsPending? | CD4 | CD4% | Viral load | ARV regimen at time of labs |
|  |  |  |  |  | [ ]  No ARVs |
|  |  |  |  |  | [ ]  No ARVs |

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| **CLINICIAN SIGNATURE** |
| **I certify that all information provided above is accurate and complete to the best of my knowledge.** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Clinician | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date Signed |