**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 | Results  Pending? | 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 |