

HIV VERIFICATION & MEDICAL INFORMATION

I hereby certify that _____ has
(Name and D.O.B.)
been tested and diagnosed as follows:

_____ HIV+
_____ Date of HIV Diagnosis
_____ AIDS
_____ Date of AIDS Diagnosis:

Physician (Please Print) Physician (Signature)

Phone _____ Date

.....
MAP Office Use Only:

CM: _____ Date Mailed: _____
Received by: _____ Date Received: _____

This form is available in **alternate formats** upon request.