VERMONT HIV/AIDS ASSISTANCE PROGRAMS

PHYSICIAN VERIFICATION OF HIV STATUS

This form is to be filled out and <u>signed by a medical provider</u> for individuals who are applying to any of the VT Dept. of Health AIDS Assistance Programs (Dental, Insurance, Medications).

Name of Patient_____

Address of Patient_____

Patient's Social Security #_____

Patient's Date of Birth_____

Name of Medical Provider_____

Telephone Number of Medical Provider_____

Patient's HIV status: ❒ HIV Positive ❒ HIV Negative

CD4 Count_____ Date Drawn___/___/___

Viral Load_____ Date Drawn___/___/___

_____ _____

Signature of Medical Provider Date

Please return this form with the completed application(s) to:

AMAP Coordinator
Vermont Department of Health
108 Cherry St., Drawer 41 HAST
P.O. Box 70,
Burlington, VT 05402-0070.
(802) 951-4005 or (800) 464-4343 ext. 4005.