KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Reportable Diseases and Conditions	**Policy #**	2.78-P
Policy Owner	Quality Improvement	**Original Effective Date**	08/1997
Revision Effective Date	10/13/2025	**Approval Date**	11/20/2025
Line of Business	☒ Medi-Cal ☒ Medicare ☐ Corporate		

I. PURPOSE

The purpose of this policy is to ensure Kern Health Systems (KHS) and its network providers comply with all state and local public health reporting requirements for communicable and non-communicable diseases and conditions. Prompt and accurate reporting supports the protection of public health by enabling timely surveillance, investigation, and control of reportable conditions as required under Title 17 California Code of Regulations (Section §2500, §2593, §2641.5-2643.20, and §2800-2812 Reportable Diseases and Conditions). This policy establishes standardized procedures for identifying, documenting, and reporting suspected or confirmed cases to the appropriate local health authority, and for maintaining internal documentation in accordance with regulatory and contractual obligations.

II. POLICY

A. It is the policy of KHS to ensure timely and accurate reporting of all communicable and non-communicable diseases and conditions as required by state and local public health authorities.
B. All KHS providers, contracted practitioners, and professional staff who diagnose, treat, or become aware of a reportable condition are responsible for notifying the appropriate local health officer in accordance with California Code of Regulations, Title 17, Section §2500, §2593, §2641.5-2643.20, and §2800-2812 Reportable Diseases and Conditions.
C. When no licensed healthcare provider is in attendance, any individual with knowledge of a suspected or confirmed reportable condition may submit a report to the local health department.
D. KHS professional licensed staff shall report identified communicable diseases or notify the member's primary care provider (PCP) of the reporting requirement following Kern County Public Health guidelines.
E. KHS requires strict adherence to prescribed reporting timeframes, procedures, and documentation standards to support public health surveillance, outbreak control, and compliance with regulatory obligations.

III. DEFINITIONS

TERMS	DEFINITIONS
Communicable Disease	An illness caused by an infectious agent or its toxic products that is transmitted directly or indirectly from one person or animal to another.
Local Health Officer	The legally designated public health authority responsible for receiving disease reports, investigating cases, and implementing public health control measures within the jurisdiction where the patient resides.
Non-Communicable Disease/Condition	A medical condition not caused by infectious agents, such as chronic diseases, disorders characterized by lapses of consciousness, pesticide-related illness, and cancer.
Reportable Disease or Condition	Any disease, condition, or occurrence that must be reported to public health authorities under California Code of Regulations, Title 17, Section 2500, or as otherwise required by local health jurisdictions.

IV. PROCEDURES

A. Communicable Disease Reporting Procedures

1. After diagnosing or suspecting a reportable disease or condition, the provider or designee shall follow the instructions outlined on the *Confidential Morbidity Report* form (Attachment A, C, and E) and comply with all specified public health reporting requirements.
2. Reports shall be submitted within the timeframes specified for each reportable disease or condition (Attachment B), in accordance with state and local public health requirements.
3. In addition to the listed reportable diseases and conditions, any occurrence of an unusual disease or outbreak of any disease shall be reported to the local health officer immediately.
4. Reports for conditions or diseases requiring immediate notification shall be made by contacting the Kern County Public Health Communicable Disease Desk at (661) 321-3000 during business hours, or (661) 324-6551 after hours, and requesting the Health Officer on call.
5. When reporting an outbreak of any disease, the report shall specify whether the outbreak occurred in an institutional setting or within the open community.
6. Reports for conditions or diseases requiring notification within one (1) working day shall be submitted by mail, fax, or telephone within one working day of identifying the confirmed or suspected case.
7. Reports for conditions or diseases requiring notification within seven (7) calendar days shall be submitted by mail, fax, or telephone within seven days of identifying the confirmed or suspected case.

B. Non-Communicable Disease and Condition Reporting Procedures

1. The following non-communicable diseases and conditions shall be reported to the local health officer within seven (7) calendar days of identification of a confirmed or suspected case:
    a. Alzheimer's disease and related conditions (Attachment D).

b. Disorders characterized by lapses of consciousness (Attachment D).
c. Pesticide-related illness or injury (known or suspected) (Attachment A).
d. Cancer, including benign and borderline brain tumors, except basal or squamous cell skin cancers unless occurring on the genitalia, and carcinoma in situ (CIN III) of the cervix (Attachment A).

C. Follow-up Procedures

1. The provider shall notify all clinical or administrative staff who had contact with the affected member and implement appropriate follow-up actions as recommended by public health authorities.

D. Internal Documentation

1. Copies of all reporting documents generated or received by KHS staff shall be maintained on file within the KHS Quality Improvement Department.
2. Documentation shall include the disease or condition reported, the date and method of reporting, and the receiving public health agency.
3. Records shall be retained in accordance with KHS record retention policy and applicable regulatory requirements.

V. ATTACHMENTS

Attachment A:	Confidential Morbidity Report Form
Attachment B:	Reportable Diseases and Conditions
Attachment C:	Confidential Morbidity Report Form TB
Attachment D:	Confidential Morbidity Report Form Alzheimer's
Attachment E:	Confidential Morbidity Report Form COVID-19

VI. REFERENCES

Reference Type	Specific Reference
Regulatory	Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5-2643.20, and §2800-2812 Reportable Diseases and Conditions

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Revised	10/13/2025	Annual review, the policy was rewritten and transferred to the new policy template. Attachments A-E were updated. The policy was ownership was transferred from UM to QI (formally policy 3.29-P).	QI Director

Revised	07/2020	Routine review by Chief Health Services Officer and Director of Health Education & Cultural and Linguistics.	UM Director
Revised	09/2015	Policy updated by Health Education and Disease Management Manager. New Morbidity Reports added.	UM Director
Revised	02/2005	Routine review.	UM Director
Revised	01/2002	Revisions made to comply with Emergency Regulations R-58-00E (Disease Reporting to Assess Potential Bioterrorism Events). Name change from Communicable Disease Reporting. Combined all conditions/diseases listed into one table. Changes were not marked if the information was simply moved into the table.	UM Director
Revised	06/2000	Routine review.	UM Director
Effective	08/1997	Original effective date.	UM Director

VIII. APPROVALS

Committees | Board (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		
Choose an item.		

CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Use this form for reporting all conditions except HIV/AIDS, Tuberculosis, and conditions reportable to DMV.

DISEASE BEING REPORTED

Patient Name - Last Name | ***First Name*** | ***MI***

Home Address: Number, Street | ***Apt./Unit No.***

City | ***State*** | ***ZIP Code***

Home Telephone Number | ***Cell Telephone Number*** | ***Work Telephone Number***

Email Address | ***Primary Language*** ☐ English ☐ Spanish ☐ Other: _____

Birth Date *(mm/dd/yyyy)* | ***Age*** ☐ Years ☐ Months ☐ Days

Current Gender Identity (check one)
☐ Male ☐ Female ☐ Trans male/transman ☐ Trans female/transwoman ☐ Genderqueer or non-binary ☐ Identity not listed *(specify)* _____ ☐ Declined to answer

Sex Assigned at Birth (check one)
☐ Male ☐ Female ☐ Declined to answer

Ethnicity (check one)
☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

Race (check all that apply)
☐ African-American/Black
☐ American Indian/Alaska Native
☐ Asian *(check all that apply)*
- ☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Hmong ☐ Japanese ☐ Korean ☐ Laotian ☐ Thai ☐ Vietnamese ☐ Other *(specify)*: _____

☐ Pacific Islander *(check all that apply)*
- ☐ Native Hawaiian ☐ Samoan ☐ Guamanian ☐ Other *(specify)*: _____

☐ White
☐ Other *(specify)*: _____
☐ Unknown

Sexual Orientation (check one)
☐ Heterosexual or straight ☐ Bisexual ☐ Gay, lesbian, or same gender loving ☐ Orientation not listed *(specify)* _____ ☐ Questioning/Unsure/ Client doesn't know ☐ Declined to answer

Pregnant? ☐ Yes ☐ No ☐ Unknown | ***Est. Delivery Date*** *(mm/dd/yyyy)* | ***Country of Birth***

Occupation or Job Title | ***Occupational or Exposure Setting (check all that apply):*** ☐ Food Service ☐ Day Care ☐ Health Care ☐ Correctional Facility ☐ School ☐ Other *(specify)*: _____

Date of Onset *(mm/dd/yyyy)* | ***Date of First Specimen Collection*** *(mm/dd/yyyy)* | ***Date of Diagnosis*** *(mm/dd/yyyy)* | ***Date of Death*** *(mm/dd/yyyy)*

Reporting Health Care Provider | ***Reporting Health Care Facility***

Address: Number, Street | ***Suite/Unit No.***

City | ***State*** | ***ZIP Code***

Telephone Number | ***Fax Number***

Submitted by | ***Date Submitted*** *(mm/dd/yyyy)*

REPORT TO:

(Obtain additional forms from your local health department.)

Laboratory Name | ***City*** | ***State*** | ***ZIP Code***

SEXUALLY TRANSMITTED DISEASES (STDs)

Gender of Sex Partners *(check all that apply)*
☐ Male ☐ Female ☐ Unknown ☐ M to F Transgender ☐ F to M Transgender ☐ Other: _____

STD TREATMENT ☐ Treated in office ☐ Given prescription
Drug(s), Dosage, Route | **Treatment Began** *(mm/dd/yyyy)*
_____ _____
_____ _____

☐ ***Untreated***
☐ Will treat
☐ Unable to contact patient
☐ Patient refused treatment
☐ Referred to: _____

If reporting Syphilis, Stage:
☐ Primary (lesion present)
☐ Secondary
☐ Early, non-primary, non-secondary
☐ Unknown Duration or Late
☐ Congenital

Clinical Manifestations?
☐ Neurologic ☐ Otic ☐ Ocular ☐ Late clinical

Syphilis Test Results | ***Titer***
☐ RPR ☐ Pos ☐ Neg _____
☐ VDRL ☐ Pos ☐ Neg _____
☐ FTA-ABS ☐ Pos ☐ Neg
☐ TP-PA ☐ Pos ☐ Neg
☐ EIA/CLIA ☐ Pos ☐ Neg
☐ CSF-VDRL ☐ Pos ☐ Neg _____
☐ Other: _____

If reporting Gonorrhea:
Specimen Source(s) *(check all that apply)*
☐ Cervical ☐ Pharyngeal ☐ Rectal ☐ Urethral ☐ Urine ☐ Vaginal ☐ Other: _____

Symptoms?
☐ Yes ☐ No ☐ Unknown

Partner(s) Treated?
☐ Yes, treated in this clinic
☐ Yes, Meds/Prescription given to patient for their partner(s)
☐ Yes, other: _____
☐ No, instructed patient to refer partner(s) for treatment
☐ No, referred partner(s) to: _____
☐ Unknown

Remarks:

CONFIDENTIAL MORBIDITY REPORT
(continued)

Patient Name - Last Name	***First Name***	***MI***	***Birth Date*** *(mm/dd/yyyy)*

VIRAL HEPATITIS

Diagnosis (check all that apply)

- ☐ Hepatitis A
- ☐ Hepatitis B (acute)
- ☐ Hepatitis B (chronic)
- ☐ Hepatitis B (perinatal)
- ☐ Hepatitis C (acute)
- ☐ Hepatitis C (chronic)
- ☐ Hepatitis C (perinatal)
- ☐ Hepatitis D (acute)
- ☐ Hepatitis D (chronic)
- ☐ Hepatitis E

Is patient symptomatic? ☐ Yes ☐ No ☐ Unknown

Suspected Exposure Type(s)

- ☐ Blood transfusion, dental or medical procedure
- ☐ IV drug use
- ☐ Other needle exposure
- ☐ Sexual contact
- ☐ Household contact
- ☐ Perinatal
- ☐ Child care
- ☐ Other: _____

ALT (SGPT) Result: _____ Upper Limit: _____

AST (SGOT) Result: _____ Upper Limit: _____

Bilirubin result: _____

		Pos	Neg
Hep A	anti-HAV IgM	☐	☐
Hep B	HBsAg	☐	☐
	anti-HBc total	☐	☐
	anti-HBc IgM	☐	☐
	anti-HBs	☐	☐
	HBeAg	☐	☐
	anti-HBe	☐	☐
	HBV DNA: _____		

		Pos	Neg
Hep C	anti-HCV	☐	☐
	RIBA	☐	☐
	HCV RNA (e.g., PCR)	☐	☐
Hep D	anti-HDV	☐	☐
Hep E	anti-HEV	☐	☐

Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5-2643.20, and §2800-2812 Reportable Diseases and Conditions*

§ 2500. REPORTING TO THE LOCAL HEALTH AUTHORITY.

- **§ 2500(b)** It shall be the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or condition listed below, to report to the local health officer for the jurisdiction where the patient resides. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed below may make such a report to the local health officer for the jurisdiction where the patient resides.
- **§ 2500(c)** The administrator of each health facility, clinic, or other setting where more than one health care provider may know of a case, a suspected case or an outbreak of disease within the facility shall establish and be responsible for administrative procedures to assure that reports are made to the local officer.
- **§ 2500(a)(15)** "Health care provider" means a physician and surgeon, a veterinarian, a podiatrist, a nurse practitioner, a physician assistant, a registered nurse, a nurse midwife, a school nurse, an infection control practitioner, a medical examiner, a coroner, or a dentist.

URGENCY REPORTING REQUIREMENTS [17 CCR §2500(h)(i)]

✆ ! = Report immediately by telephone (designated by a ♦ in regulations).

† = Report immediately by telephone when two or more cases or suspected cases of foodborne disease from separate households are suspected to have the same source of illness (designated by a • in regulations).

✆ = Report by telephone within one working day of identification (designated by a + in regulations).

FAX ✆ ✉ = Report by electronic transmission (including FAX), telephone, or mail within one working day of identification (designated by a + in regulations).

WEEK = All other diseases/conditions should be reported by electronic transmission (including FAX), telephone, or mail within seven calendar days of identification.

REPORTABLE COMMUNICABLE DISEASES §2500(j)

Disease Name	Urgency	Disease Name	Urgency
Anaplasmosis	WEEK	Listeriosis	FAX ✆ ✉
Anthrax, human or animal	✆ !	Lyme Disease	WEEK
Babesiosis	FAX ✆ ✉	Malaria	FAX ✆ ✉
Botulism (Infant, Foodborne, wound, Other)	✆ !	Measles (Rubeola)	✆ !
Brucellosis, animal (except infections due to *Brucella canis*)	WEEK	Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic	FAX ✆ ✉
Brucellosis, human	✆ !	Meningococcal Infections	✆ !
Campylobacteriosis	FAX ✆ ✉	Middle East Respiratory Syndrome (MERS)	✆ !
Candida auris, colonization or infection	✆	Monkeypox or orthopox virus infection	✆
Chancroid	WEEK	Mumps	WEEK
Chickenpox (Varicella) (outbreaks, hospitalizations and deaths)	FAX ✆ ✉	Novel Coronavirus Infection	✆ !
Chikungunya Virus Infection	FAX ✆ ✉	Novel Virus Infection with Pandemic Potential	✆ !
Cholera	✆ !	Paralytic Shellfish Poisoning	✆ !
Ciguatera Fish Poisoning	✆ !	Paratyphoid Fever	FAX ✆ ✉
Coccidioidomycosis	WEEK	Pertussis (Whooping Cough)	FAX ✆ ✉
Coronavirus Disease 2019 (COVID-19)	✆	Plague, human or animal	✆ !

Disease Name	Urgency	Disease Name	Urgency
Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)	WEEK	Poliovirus Infection	✆ !
Cryptosporidiosis	FAX ✆ ✉	Psittacosis	FAX ✆ ✉
Cyclosporiasis	WEEK	Q Fever	FAX ✆ ✉
Cysticercosis or taeniasis	WEEK	Rabies, human or animal	✆ !
Dengue Virus Infection	FAX ✆ ✉	Relapsing Fever	FAX ✆ ✉
Diphtheria	✆ !	Respiratory Syncytial Virus-associated deaths in laboratory-confirmed cases less than five years of age	WEEK
Domoic Acid Poisoning (Amnesic Shellfish Poisoning)	✆ !	Rickettsial Diseases (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-like illnesses	WEEK
Ehrlichiosis	WEEK	Rocky Mountain Spotted Fever	WEEK
Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic	FAX ✆ ✉	Rubella (German Measles)	WEEK
Escherichia coli: shiga toxin producing (STEC) including *E. coli* O157	✆ !	Rubella Syndrome, Congenital	WEEK
Flavivirus infection of undetermined species	✆ !	Salmonellosis (Other than Typhoid Fever)	FAX ✆ ✉
Foodborne Disease	† FAX ✆ ✉	Scombroid Fish Poisoning	✆ !
Giardiasis	WEEK	Shiga toxin (detected in feces)	✆ !
Gonococcal Infections	WEEK	Shigellosis	FAX ✆ ✉
Haemophilus influenzae, invasive disease, all serotypes (report an incident less than 5 years of age)	FAX ✆ ✉	Smallpox(Variola)	✆ !
Hantavirus Infections	FAX ✆ ✉	Syphilis (all stages, including congenital)	FAX ✆ ✉
Hemolytic Uremic Syndrome	✆ !	Tetanus	WEEK
Hepatitis A, acute infection	FAX ✆ ✉	Trichinosis	FAX ✆ ✉
Hepatitis B (specify acute, chronic, or perinatal)	WEEK	Tuberculosis	FAX ✆ ✉
Hepatitis C (specify acute, chronic, or perinatal)	WEEK	Tularemia, animal	WEEK
Hepatitis D (Delta) (specify acute case or chronic)	WEEK	Tularemia, human	✆ !
Hepatitis E, acute infection	WEEK	Typhoid Fever, Cases and Carriers	FAX ✆ ✉
Human Immunodeficiency Virus (HIV), acute infection	✆	*Vibrio* Infections	FAX ✆ ✉
Human Immunodeficiency Virus (HIV) infection, any stage	WEEK	Viral Hemorrhagic Fevers, human or animal (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses)	✆ !
Human Immunodeficiency Virus (HIV) infection, progression to stage 3 (AIDS)	WEEK	West Nile Virus (WNV) Infection	FAX ✆ ✉

Disease Name	Urgency	Disease Name	Urgency
Influenza-associate deaths in laboratory-confirmed cases less than 18 years of age	WEEK	Yellow Fever	FAX ✆ ✉
Influenza due to novel strains (human)	✆ !	Yersiniosis	FAX ✆ ✉
Legionellosis	WEEK	Zika Virus Infection	FAX ✆ ✉
Leprosy (Hansen Disease)	WEEK	OCCURRENCE of ANY UNUSUAL DISEASE	✆ !
Leptospirosis	WEEK	OUTBREAKS of ANY DISEASE (Including diseases not listed in **§2500**). Specify if institutional and/or open community.	✆ !

HIV REPORTING BY HEALTH CARE PROVIDERS §2641.30-2643.20

Human Immunodeficiency Virus (HIV) infection at all stages is reportable by traceable mail, person-to-person transfer, or electronically within seven calendar days. For complete HIV-specific reporting requirements, see Title 17, CCR, §2641.30-2643.20 and the California Department of Public Health's HIV Surveillance and Case Reporting Resource page (https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_case_surveillance_resources.aspx)

REPORTABLE NONCOMMUNICABLE DISEASES AND CONDITIONS §2800–2812 and §2593(b)

Disorders Characterized by Lapses of Consciousness (§2800-2812)

Pesticide-related illness or injury (known or suspected cases)**

Cancer, including benign and borderline brain tumors (except (1) basal and squamous skin cancer unless occurring on genitalia, and (2) carcinoma in-situ and CIN III of the Cervix) (§2593)***

LOCALLY REPORTABLE DISEASES (If Applicable):

* This form is designed for health care providers to report those diseases mandated by Title 17, California Code of Regulations (CCR). Failure to report is a misdemeanor (Health & Safety Code §120295) and is a citable offense under the Medical Board of California Citation and Fine Program (Title 16, CCR, §1364.10 and 1364.11).

** Failure to report is a citable offense and subject to civil penalty ($250) (Health and Safety Code §105200).

*** The Confidential Physician Cancer Reporting Form may also be used. See Physician Reporting Requirements for Cancer Reporting in CA at: www.ccrcal.org

Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5-2643.20, and §2800-2812 Reportable Diseases and Conditions*

§ 2500. REPORTING TO THE LOCAL HEALTH AUTHORITY.

- **§ 2500(b)** It shall be the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or condition listed below, to report to the local health officer for the jurisdiction where the patient resides. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed below may make such a report to the local health officer for the jurisdiction where the patient resides.
- **§ 2500(c)** The administrator of each health facility, clinic, or other setting where more than one health care provider may know of a case, a suspected case or an outbreak of disease within the facility shall establish and be responsible for administrative procedures to assure that reports are made to the local officer.
- **§ 2500(a)(14)** "Health care provider" means a physician and surgeon, a veterinarian, a podiatrist, a nurse practitioner, a physician assistant, a registered nurse, a nurse midwife, a school nurse, an infection control practitioner, a medical examiner, a coroner, or a dentist.

URGENCY REPORTING REQUIREMENTS [17 CCR §2500(h)(i)]

✆! = Report immediately by telephone (designated by a ♦ in regulations).
† = Report immediately by telephone when two or more cases or suspected cases of foodborne disease from separate households are suspected to have the same source of illness (designated by a ● in regulations).
✆ = Report by telephone within one working day of identification (designated by a + in regulations).
FAX ✆✉ = Report by electronic transmission (including FAX), telephone, or mail within one working day of identification (designated by a + in regulations).
WEEK = All other diseases/conditions should be reported by electronic transmission (including FAX), telephone, or mail within seven calendar days of identification.

REPORTABLE COMMUNICABLE DISEASES §2500(j)

Disease Name	Urgency	Disease Name	Urgency
Anaplasmosis	WEEK	Lyme Disease	WEEK
Anthrax, human or animal	✆!	Malaria	FAX ✆✉
Babesiosis	FAX ✆✉	Measles (Rubeola)	✆!
Botulism (Infant, Foodborne, Wound, Other)	✆!	Melioidosis	✆!
Brucellosis, animal (except infections due to *Brucella canis*)	WEEK	Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic	FAX ✆✉
Brucellosis, human	FAX ✆✉	Middle East Respiratory Syndrome (MERS)	✆!
Campylobacteriosis	FAX ✆✉	Monkeypox or orthopox virus infection	✆!
Candida auris, colonization or infection	FAX ✆✉	Multisystem inflammatory syndrome in children (MIS-C)	FAX ✆✉

Disease Name	Urgency	Disease Name	Urgency
Chancroid	WEEK	Mumps	WEEK
Chickenpox (Varicella)(Outbreaks, hospitalizations and deaths)	FAX ✆✉	*Neisseria meningitidis* (invasive disease)	✆!
Chikungunya Virus Infection	FAX ✆✉	Novel Coronavirus Infection	✆!
Cholera	✆!	Novel Virus Infection with Pandemic Potential	✆!
Ciguatera Fish Poisoning	✆!	Paralytic Shellfish Poisoning	✆!
Coccidioidomycosis	WEEK	Paratyphoid Fever	FAX ✆✉
Coronavirus Disease 2019 (COVID-19) (hospitalizations only)	FAX ✆✉	Pertussis (Whooping Cough)	FAX ✆✉
Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)	WEEK	Plague, human or animal	✆!
Cronobacter sakazakii infections in infants less than one year of age	FAX ✆✉	Poliovirus Infection	FAX ✆✉
Cryptosporidiosis	FAX ✆✉	Psittacosis	FAX ✆✉
Cyclosporiasis	FAX ✆✉	Q Fever	FAX ✆✉
Cysticercosis or taeniasis	WEEK	Rabies, human or animal	✆!
Dengue Virus Infection	FAX ✆✉	Relapsing Fever	FAX ✆✉
Diphtheria	✆!	Respiratory Syncytial Virus-associated deaths in laboratory-confirmed cases less than five years of age	WEEK
Domoic Acid Poisoning (Amnesic Shellfish Poisoning)	✆!	Rickettsial Diseases (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-like illnesses	WEEK
Ehrlichiosis	WEEK	Rocky Mountain Spotted Fever	WEEK
Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic	FAX ✆✉	Rubella (German Measles)	WEEK
Escherichia coli: shiga toxin producing (STEC) including *E. coli* O157	FAX ✆✉	Rubella Syndrome, Congenital	WEEK
Flavivirus infection of undetermined species	✆!	Salmonellosis (Other than Typhoid Fever)	FAX ✆✉
Foodborne Disease	†FAX ✆✉	Scombroid Fish Poisoning	✆!
Giardiasis	WEEK	Shiga toxin (detected in feces)	FAX ✆✉
Gonococcal Infections	WEEK	Shigellosis	FAX ✆✉
Haemophilus influenzae, invasive disease, all serotypes (report an incident less than 5 years of age)	FAX ✆✉	Silicosis	WEEK

Disease Name	Urgency	Disease Name	Urgency
Hantavirus infections	FAX ✆✉	Syphilis (all stages, including congenital)	FAX ✆✉
Hemolytic Uremic Syndrome	FAX ✆✉	Tetanus	WEEK
Hepatitis A, acute infection	FAX ✆✉	Trichinosis	FAX ✆✉
Hepatitis B (specify acute, chronic, or perinatal)	WEEK	Tuberculosis	FAX ✆✉
Hepatitis C (specify acute, chronic, or perinatal)	WEEK	Tularemia, animal	WEEK
Hepatitis D (Delta) (specify acute case or chronic)	WEEK	Tularemia, human	✆!
Hepatitis E, acute infection	WEEK	Typhoid Fever, Cases and Carriers	FAX ✆✉
Human Immunodeficiency Virus (HIV) infection, acute infection	✆	*Vibrio* Infections	FAX ✆✉
Human Immunodeficiency Virus (HIV) infection, any stage	WEEK	Viral Hemorrhagic Fevers, human or animal (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses)	✆!
Human Immunodeficiency Virus (HIV) infection, progression to stage 3 (AIDS)	WEEK	West Nile Virus (WNV) Infection	FAX ✆✉
Influenza-associated deaths in laboratory- confirmed cases less than 18 years of age	WEEK	Yellow Fever	FAX ✆✉
Influenza due to novel strains (humans)	✆!	Yersiniosis	FAX ✆✉
Legionellosis	FAX ✆✉	Zika Virus Infection	FAX ✆✉
Leprosy (Hansen Disease)	WEEK	OCCURANCE of ANY UNUSUAL DISEASE	✆!
Leptospirosis	WEEK	OUTBREAKS of ANY DISEASE (Including diseases not listed in **§2500**). Specify if institutional and/or open community.	✆!
Listeriosis	FAX ✆✉		

HIV REPORTING BY HEALTH CARE PROVIDERS §2641.30-2643.20

Human Immunodeficiency Virus (HIV) infection at all stages is reportable by traceable mail, person-to-person transfer, or electronically within seven calendar days. For complete HIV-specific reporting requirements, see Title 17, CCR, §2641.30-2643.20 and the California Department of Public Health's HIV Surveillance and Case Reporting Resource page (www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_case_surveillance_resources.aspx)

REPORTABLE NONCOMMUNICABLE DISEASES AND CONDITIONS §2800–2812 and §2593(b)

Disorders Characterized by Lapses of Consciousness (§2800-2812)

Pesticide-related illness or injury (known or suspected cases)**

Cancer, including benign and borderline brain tumors (except (1) basal and squamous skin cancer unless occurring on genitalia, and (2) carcinoma in-situ and CIN III of the Cervix) (§2593)***

LOCALLY REPORTABLE DISEASES (If Applicable):

* The Confidential Morbidity Report (CMR) is designed for health care providers to report those diseases mandated by Title 17, California Code of Regulations (CCR). The CMR form can be found here: Communicable Disease Reporting Forms . Failure to report is a misdemeanor (Health & Safety Code §120295) and is a citable offense under the Medical Board of California Citation and Fine Program (Title 16, CCR, §1364.10 and 1364.11).

** Failure to report is a citable offense and subject to civil penalty ($250) (Health and Safety Code §105200).

*** The Confidential Physician Cancer Reporting Form may also be used. See Physician Reporting Requirements for Cancer Reporting in CA at: www.ccrcal.org.

Revised 06/2025

CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Only use this form for reporting Tuberculosis. Report to local health department within one working day.

DISEASE BEING REPORTED Tuberculosis

Patient Name - Last Name | ***First Name*** | ***MI***

Home Address: Number, Street | ***Apt./Unit No.***

City | ***State*** | ***ZIP Code***

Home Telephone Number | ***Cell Telephone Number*** | ***Work Telephone Number***

Email Address | ***Primary Language*** ☐ English ☐ Spanish ☐ Other: _____

Birth Date *(mm/dd/yyyy)* | ***Age*** ☐ Years ☐ Months ☐ Days | ***Gender*** ☐ Male ☐ Female ☐ M to F Transgender ☐ F to M Transgender ☐ Other: _____

Pregnant? ☐ Yes ☐ No ☐ Unknown | ***Est. Delivery Date*** *(mm/dd/yyyy)* | ***Country of Birth***

Ethnicity (check one)
☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

Race (check all that apply)
☐ African-American/Black
☐ American Indian/Alaska Native
☐ Asian *(check all that apply)*
☐ Asian Indian ☐ Hmong ☐ Thai
☐ Cambodian ☐ Japanese ☐ Vietnamese
☐ Chinese ☐ Korean ☐ Other *(specify)*: _____
☐ Filipino ☐ Laotian
☐ Pacific Islander *(check all that apply)*
☐ Native Hawaiian ☐ Samoan
☐ Guamanian ☐ Other *(specify)*: _____
☐ White
☐ Other *(specify)*: _____
☐ Unknown

Occupation or Job Title

Occupational or Exposure Setting (check all that apply): ☐ Food Service ☐ Day Care ☐ Health Care ☐ Correctional Facility ☐ School ☐ Other *(specify)*: _____

Date of Onset *(mm/dd/yyyy)* | ***Date of First Specimen Collection*** *(mm/dd/yyyy)* | ***Date of Diagnosis*** *(mm/dd/yyyy)* | ***Date of Death*** *(mm/dd/yyyy)*

Reporting Health Care Provider | ***Reporting Health Care Facility***

Address: Number, Street | ***Suite/Unit No.***

City | ***State*** | ***ZIP Code***

Telephone Number | ***Fax Number***

Submitted by | ***Date Submitted*** *(mm/dd/yyyy)*

REPORT TO:

(Obtain additional forms from your local health department.)

Laboratory Name | ***City*** | ***State*** | ***ZIP Code***

TUBERCULOSIS (TB)

Status
☐ Active Disease
☐ Confirmed
☐ Suspected
☐ Infected, No Disease
☐ Converter*

* For TST, an increase of ≥10 mm in induration size during ≤2 years.

Sites(s)
☐ Pulmonary
☐ Extra-Pulmonary
☐ Both

Mantoux TB Skin Test
_____ Date Placed *(mm/dd/yyyy)*
_____ Date Read *(mm/dd/yyyy)*
Results: _____ mm ☐ Not done ☐ Pending ☐ Not read

Interferon Gamma Release Assay (IGRA)
Date Collected: _____ *(mm/dd/yyyy)*
Specify test name: _____
Results: ☐ Positive ☐ Indeterminate ☐ Negative ☐ Not done ☐ Unknown

Imaging: ☐ *Chest X-Ray* ☐ *Chest CT Scan or Other Chest Imaging Study*
Date Performed: _____ *(mm/dd/yyyy)*
Results: ☐ Normal ☐ Pending ☐ Cavitary ☐ Abnormal/Noncavitary ☐ Not done

Bacteriology/Pathology
Please mark positive on smear or culture if any of initial specimens obtained was positive
Date Specimen Collected: _____ *(mm/dd/yyyy)*
Source: _____
Smear for acid-fast bacilli: ☐ Pos ☐ Neg ☐ Pending ☐ Not done
Culture for *M. tuberculosis* complex: ☐ Pos ☐ Neg ☐ Pending ☐ Not done
Pathology suggests TB ☐
Rapid Drug Resistance Assay
☐ INH resistance ☐ Not done
☐ RIF resistance
☐ No INH or RIF resistance detected

Nucleic Acid Amplification/PCR Test for M. tuberculosis complex
Specify test type: _____
Results: ☐ Pos ☐ Indeterminate ☐ Neg ☐ Not done
Other test(s): _____

TB TREATMENT INFORMATION

☐ **Current Treatment** *(check all that apply)*
☐ INH ☐ RIF ☐ PZA
☐ EMB
☐ Other: _____
☐ Other: _____
☐ Other: _____

Date Treatment Initiated: _____ *(mm/dd/yyyy)*

☐ ***Drug resistance suspected***

☐ ***Untreated***
☐ Will treat
☐ Unable to contact patient
☐ Patient refused treatment
☐ Other: _____
☐ Referred to: _____

Remarks:

CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Use this form for reporting lapses of consciousness, Alzheimer's disease or other conditions which may impair the ability to operate a motor vehicle safely (pursuant to H&S 103900).

CONDITION BEING REPORTED

Patient Name - Last Name | ***First Name*** | ***MI***

Home Address: Number, Street | ***Apt./Unit No.***

City | ***State*** | ***ZIP Code***

Home Telephone Number | ***Cell Telephone Number*** | ***Work Telephone Number***

Email Address | ***Primary Language*** ☐ English ☐ Spanish ☐ Other: _____

Birth Date *(mm/dd/yyyy)* | ***Age*** ☐ Years ☐ Months ☐ Days | ***Gender*** ☐ Male ☐ Female ☐ M to F Transgender ☐ F to M Transgender ☐ Other: _____

Pregnant? ☐ Yes ☐ No ☐ Unknown | ***Est. Delivery Date*** *(mm/dd/yyyy)* | ***Country of Birth***

Ethnicity (check one)
☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

Race (check all that apply)
African-American/Black
American Indian/Alaska Native
Asian *(check all that apply)*
Asian Indian ☐ Hmong ☐ Thai
Cambodian ☐ Japanese ☐ Vietnamese
Chinese ☐ Korean ☐ Other *(specify)*:
Filipino ☐ Laotian _____
Pacific Islander *(check all that apply)*
Native Hawaiian ☐ Samoan
Guamanian ☐ Other *(specify)*: _____
White
Other *(specify)*: _____
Unknown

Occupation or Job Title

Occupational or Exposure Setting (check all that apply): ☐ Food Service ☐ Day Care ☐ Health Care ☐ Correctional Facility ☐ School ☐ Other *(specify)*: _____

Date of Onset *(mm/dd/yyyy)* | ***Date of First Specimen Collection*** *(mm/dd/yyyy)* | ***Date of Diagnosis*** *(mm/dd/yyyy)*

Reporting Health Care Provider | ***Reporting Health Care Facility***

Address: Number, Street | ***Suite/Unit No.***

City | ***State*** | ***ZIP Code***

Telephone Number | ***Fax Number***

Submitted by | ***Date Submitted*** *(mm/dd/yyyy)*

REPORT TO:

(Obtain additional forms from your local health department.)

DEPARTMENT OF MOTOR VEHICLES (DMV)

California Driver License or Identification Card Number (eight characters): ☐☐☐☐☐☐☐☐

1. If this report is based upon episodic lapses of consciousness, when was the most recent episode?: _____ *(mm/dd/yyyy)*
2. If there have been multiple episodes of loss of consciousness or control within the past three years, please indicate the dates if they are known to you.
   (a): _____ *(mm/dd/yyyy)* (b): _____ *(mm/dd/yyyy)* (c): _____ *(mm/dd/yyyy)* (d): _____ *(mm/dd/yyyy)* (e): _____ *(mm/dd/yyyy)* (f): _____ *(mm/dd/yyyy)*
3. Within the past 12 months, has there been an episode of loss of consciousness or control while driving? ☐ Yes ☐ No ☐ Uncertain
4. Are additional lapses of consciousness likely to occur? ☐ Yes ☐ No ☐ Uncertain
5. If the patient has had episodes of nocturnal seizures, is there likelihood of lapses of consciousness occurring while he/she is awake? ☐ Yes ☐ No ☐ Uncertain
6. Has this patient been diagnosed with dementia or Alzheimer's disease? ☐ Yes ☐ No ☐ Uncertain
7. Would you currently advise this patient not to drive because of his/her medical condition? ☐ Yes ☐ No ☐ Uncertain
8. Does this patient's condition represent a permanent driving disability? ☐ Yes ☐ No ☐ Uncertain
9. Would you recommend a driving evaluation by DMV? ☐ Yes ☐ No ☐ Uncertain

Remarks:

CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Only use this form for reporting COVID-19. Report to local health department within one working day.

DISEASE BEING REPORTED: COVID-19 **Please write all dates as (mm/dd/yyyy)**

Patient Name - Last Name | ***First Name*** | ***MI***

Home Address: Number, Street | ***Apt./Unit No.***

City | ***State*** | ***ZIP Code***

Home Telephone Number | ***Cell Telephone Number*** | ***Work Telephone Number***

Email Address | ***Country of Birth*** | ***Primary Language*** ☐ English ☐ Spanish ☐ Other: _____

Birth Date *(mm/dd/yyyy)* | ***Age*** ☐ Years ☐ Months ☐ Days

Current Gender Identity
- ☐ Male
- ☐ Female
- ☐ Trans male / transman
- ☐ Trans female / transwoman
- ☐ Genderqueer or non-binary
- ☐ Identity not listed (specify):_____
- ☐ Declined to answer

Sex Assigned at Birth
☐ Male ☐ Female ☐ Declined to answer

Pregnant?
☐ Yes ☐ No ☐ Unknown

If Yes, Est. Delivery Date: _____

Sexual Orientation
- ☐ Heterosexual or straight
- ☐ Bisexual
- ☐ Gay, lesbian, or same gender loving
- ☐ Orientation not listed (specify): _____
- ☐ Questioning / unsure / client doesn't know
- ☐ Declined to answer

Gender(s) of sex partners (check all that apply)
- ☐ Male
- ☐ Female
- ☐ Trans male / transman
- ☐ Trans female / transwoman
- ☐ Genderqueer or non-binary
- ☐ Identity not listed (specify):_____
- ☐ Declined to answer

Ethnicity (check one)
☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

Race (check all that apply)
- ☐ African-American/Black
- ☐ American Indian/Alaska Native
- ☐ Asian *(check all that apply)*
  - ☐ Asian Indian ☐ Hmong ☐ Thai
  - ☐ Cambodian ☐ Japanese ☐ Vietnamese
  - ☐ Chinese ☐ Korean ☐ Other (specify): _____
  - ☐ Filipino ☐ Laotian
- ☐ Pacific Islander *(check all that apply)*
  - ☐ Native Hawaiian ☐ Samoan
  - ☐ Guamanian ☐ Other (specify): _____
- ☐ White
- ☐ Other (specify): _____ ☐ Unknown

Close contact with a laboratory confirmed COVID-19 case?
☐ Yes ☐ No ☐ Unknown

If Yes, type of contact:
- ☐ Household contact
- ☐ Community contact
- ☐ Any healthcare contact
- ☐ Workplace contact

Additional Contact Details *(if applies)*

Congregate setting *(check if applies)*
☐ Staff ☐ Resident ☐ Unknown
☐ Assisted Living Facility ☐ Skilled Nursing Facility ☐ Shelter
☐ Correctional Facility ☐ Hospital-Based Facility ☐ Clinic
☐ Other (specify):

Name,City of Congregate Setting(s) *(if applies):*

Occupation or Job Title
☐ Healthcare worker ☐ In healthcare setting

Housing Status
☐ Stable ☐ Unstable ☐ Unknown

Reporting Health Care Provider | ***Reporting Health Care Facility***

Address: Number, Street | ***Suite/Unit No.***

City | ***State*** | ***ZIP Code***

Telephone Number | ***Fax Number***

Email Address: | ***Date Submitted***

REPORT TO:

(Obtain additional forms from your local health department.)

Laboratory Name | ***City*** | ***State*** | ***ZIP Code***

Continued on next page.

CONFIDENTIAL MORBIDITY REPORT – COVID-19 (continued)

Patient Name - Last Name	*First Name*	*MI*	*Birth Date (mm/dd/yyyy)*

COVID-19: Hospitalization Status and Diagnostic Testing

Diagnosis Date:

Status at Time of Report

- ☐ Hospitalized, ICU
  - ☐ Intubated
  - ☐ Not Intubated
- ☐ Hospitalized, non-ICU
- ☐ Not Hospitalized
- ☐ Deceased

Date of Death (if applies)

Complete dates where applies

Date Hospitalized (if ever hospitalized)

Date Discharged (if previously hospitalized)

Date Intubated (if ever intubated)

Status History

Ever Hospitalized?	☐ Yes	☐ No
Ever in ICU?	☐ Yes	☐ No
Ever Intubated?	☐ Yes	☐ No
Ever Placed on ECMO?	☐ Yes	☐ No

Respiratory Complications

Clinical or Radiologic Evidence of Pneumonia *(check all that apply)*

- ☐ None
- ☐ Clinical
- ☐ Radiologic

Clinical or Radiologic Evidence of ARDS *(check all that apply)*

- ☐ None
- ☐ Clinical
- ☐ Radiologic

Imaging performed *(check all that apply)*

- ☐ Chest X-Ray — Date Performed
- ☐ Chest CT Scan — Date Performed
- ☐ Other Chest Imaging Study — Date Performed

COVID-19 Testing (Complete all that apply)

- ☐ **PCR swab (NP and/or OP)**
  - Date Specimen(s) Collected
  - Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending
- ☐ **Antigen** **Test name:**_____
  - Date Specimen Collected
  - Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending
- ☐ **Serology** **Test name:**_____
  - Date Specimen Collected
  - Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending
- ☐ **Other:**_____
  - Date Specimen Collected
  - Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending
- ☐ **Not tested for COVID-19**

COVID-19 Specific Treatment(s)

Drug, Dosage, Route	Date Initiated

Clinical Information

COVID-19 Symptoms (Check all that apply)

☐ None	☐ Fever >100.4F, 38C	☐ Subjective fever
☐ Chills	☐ Rigors	☐ Runny nose
☐ Sore throat	☐ Cough	☐ Shortness of breath
☐ Difficulty breathing	☐ Muscle aches	☐ Headache
☐ Loss of smell	☐ Loss of taste	☐ Nausea
☐ Vomiting	☐ Abdominal pain	☐ Diarrhea
☐ Dermatologic finding	☐ Thromboses (e.g. stroke, DVT, PE)	

☐ Other (specify): _____

Date of first symptom onset:_____

Travel to or reside in an area with sustained, ongoing, community transmission of SARS-CoV-2?

☐ Yes ☐ No ☐ Unknown

*If yes, location(s):*_____

Other diagnosis or etiology for respiratory condition?

☐ Yes (specify):_____ ☐ No

Chronic Conditions (Check all that apply)

☐ None	☐ Unknown	☐ Diabetes
☐ Cardiovasc. disease	☐ Hypertension	☐ Asthma
☐ Chronic lung disease	☐ Chronic kidney disease	☐ Chronic liver disease
☐ Stroke	☐ Neurological/ neuro-developemental	☐ Cancer
☐ Immunocompromised	☐ Obesity	☐ Current smoker
☐ Former smoker	☐ Current e-cigarette or vape use	

☐ Other (specify):_____

Vaccination History

Received one or more doses of COVID-19 vaccine

☐ Yes ☐ No ☐ Unknown

Type of Vaccine (i.e., Pfizer, Moderna, etc.)

Date of Dose 1

Date of Dose 2

Additional Remarks