Position _____

TUBERCULOSIS TEST VERIFICATION

VOLUNTEERS

Patient Information

Last Name	First	MI	Sex	Date of Birth

Social Security Number	Home Telephone	Work Telephone

Mailing Address	Street	City	State	Zip

Usual Source of Medical Care	Physician's Name	Address	Telephone

Emergency Contact – Name	Relationship	Address	Telephone

Required Tuberculosis Test Results (as per Regulations of the Department of Health

DATE APPLIED	ARM	METHOD	ANTIGEN	MANUFACTURER	SIGNATURE
DATE READ	**RESULTS (mm)**		**SIGNATURE**		

For previously known/new positive reactors: _____

Chest X-ray: Date: _____ Results: _____
(Attach a copy of the report.)

Other: Date: _____ Results: _____
(Attach a copy of the report.)

Preventive Anti-Tuberculosis Chemotherapy ordered: ☐ No ☐ Yes Date: _____

IF SIGNIFICANT REACTION WAS REPORTED, THE PHYSICIAN REPORT MUST STATE THAT THE APPLICANT IS FREE FROM CURRENT TUBERCULOSIS DISEASE OR IS UNDER ADEQUATE CHEMOTHERAPY FOR TUBERCULOSIS DISEASE:

_____

_____

_____