

**Section A Tuberculosis Assessment (All clients must complete section "A".)**

Have you had a Positive TB Exposure or Positive TB Skin Test History (PPD, QuantiFERON-TB-Gold, T-Spot, etc)?  
 Yes  No (If YES, documentation required) **Symptom Review to be completed whether 'Yes' or 'No' to above**

- Have you experienced any of the following symptoms in the past year?
 

A) A productive cough for more than 3 days?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
B) Hemoptysis (coughing up blood)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
C) Unexplained weight loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
D) Fever, Chills, or night sweats for no known reason?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
E) Persistent shortness of breath?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
F) Unexplained fatigue?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
G) Chest Pain?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
- Have you had contact with anyone with active tuberculosis disease in the past year?  Yes  No
- Do you have a medical condition, or are you taking medications, which suppress your immune system?  Yes  No

I have read and completed the signs and symptoms for Tuberculosis screening questions above. My answers are true to the best of my knowledge. If there are any changes in my health status related to TB signs and symptoms I will report them to the Company without delay. I realize that I must have clearance from my physician to return to work if I experience above signs/symptoms of active TB.

Client Name: \_\_\_\_\_ PRINT Client Signature: \_\_\_\_\_ SIGNATURE Date: \_\_\_\_\_ MM/DD/YYYY

**Section B Tuberculosis Screening (Please attach all lab results / immunization records)**

The following tests have been performed in my office/facility and under my supervision by medical personnel with training to place and read a PPD/Skin Test.

**PPD/SKIN TEST**

Placed: \_\_\_\_\_ Placed by: \_\_\_\_\_  
MM/DD/YYYY NAME SIGNATURE

Time: \_\_\_\_\_: \_\_\_\_\_ a.m. / p.m. \_\_\_\_\_  
TITLE

Manufacturer: \_\_\_\_\_ Office/Facility Name: \_\_\_\_\_

Exp Date: \_\_\_\_\_ Address: \_\_\_\_\_  
MM/DD/YYYY

Lot #: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Read: \_\_\_\_\_ Interpreted by: \_\_\_\_\_  
MM/DD/YYYY NAME SIGNATURE

Time: \_\_\_\_\_: \_\_\_\_\_ a.m. / p.m. \_\_\_\_\_  
TITLE

Office/Facility Name is the same as above.

Office/Facility Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Telephone #: \_\_\_\_\_

**RESULTS and/or**

**BCG Immunization**

**QuantiFERON-TB-Gold**

**T-SPOT**

Induration \_\_\_\_\_ mm  Negative  Positive

Date: \_\_\_\_\_  
MM/DD/YYYY

Date: \_\_\_\_\_  
MM/DD/YYYY

Date: \_\_\_\_\_  
MM/DD/YYYY

**Section C Tuberculosis History**

**Complete Section C only if there is a history of Positive TB Exposure.**

Please provide most recent Chest X-ray radiology report.

Positive TB Skin Test (documentation required) Date: \_\_\_\_\_  
MM/DD/YYYY

Have you been treated with TB medication?  Yes  No

Treatment:  INH  Other

Chest X-Ray impression relative to positive PPD:  Positive  Negative Date \_\_\_\_\_  
MM/DD/YYYY