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DEPARTMENT OF EDUCATION
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TUBERCULOSIS (TB) SCREENING FORM

Please have this form completed by your Health Care Provider (HCP) and then submit it to your worksite and/or the Human Resources Division as soon as possible or as instructed. This is necessary to comply with 10 GCA, Chapter 25, Subsection 25103, which requires a TB skin test or TB Clearance results on file prior to employment or volunteer work and annually thereafter. Failure to comply will result in your disqualification for employment or volunteer work, or may be grounds for placing you on leave without pay until the required documentation is submitted.

Please note the following:

- Applicants for employment must first submit a copy of this form (or other authorized form) to the Human Resources Division for verification and must, upon hire, provide a copy to the assigned worksite.

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Name of Employee_____ Date of Birth _____
(Last) (First) (Middle)

Employee ID # _____ Work Location _____

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INSTRUCTIONS
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Please complete all items as directed. Where a signature is required, please ensure that the information requested is completed accordingly by a physician, physician's assistant (PA), nurse practitioner (NP), or nurse (RN/LPN). Refer to each item for specifics.

1. A) Obtain TB skin test unless contraindicated by your HCP;
   B) Have the TB skin test information completed by the HCP or attach medical documentation to this form which shows the date of TB skin test administration and results (The date of result must be less than a year old from the effective date of your employment or start of your volunteer work).

► Date administered: _____

_____ _____.
Name of Physician/PA/NP/RN/LPN (print) Signature

► Date read: _____ Result: _____mm ☐ NEGATIVE ☐ POSITIVE

_____ _____.
Name of Physician/PA/NP/RN/LPN (print) Signature

2. A) If you are a known positive TB reactor, you and your HCP must complete the Latent TB Questionnaire at the back of this form.
   B) If you are cleared for work, please ensure that your HCP identifies whether it is temporary or not. If your TB clearance is temporary, it is your responsibility to ensure that an updated TB Clearance form is submitted to your worksite before your temporary clearance expires.

LATENT TUBERCULOSIS INFECTION (LTBI) QUESTIONNAIRE

If you are a known positive TB reactor, please answer Item No. 3 below. Your Health Care Provider (HCP) will complete Item Nos. 4 & 5. Please follow the instructions given by your HCP when submitting this form.

3. Have you been exposed to active TB? ☐ YES ☐ NO

SYMPTOMS	YES	NO	REMINDER TO HEALTH CARE PROVIDER
Cough			*If response is "yes" to any of the symptoms, patient will need a Repeat 2 view CXR before referral to Public Health for Clearance.* Please include findings from repeat CXR (Copy of report **MUST** be attached): ☐ **NORMAL** ☐ **ABNORMAL**
Fever			
Weight Loss			
Night Sweats			
Fatigue			
Chest Pain			
Shortness of Breath			
Hoarseness			

To be completed by HCP.

4. Treatment Results.

TB SKIN TEST	Date given:	Date read:	Results: _____mm
CHEST X-RAY (Copy of report MUST be attached)	Date of CXR exam:	☐ Normal ☐ Abnormal	Comments:
LTBI TREATMENT	Date treatment started:	Date completed:	☐ No h/o treatment
	Adverse reactions to LTBI therapy?	☐ Yes ☐ No	Patient declined therapy? ☐ Yes ☐ No

5. TB Clearance Results.

Patient is ***temporarily*** cleared for work (valid for 90 days).	☐ YES	☐ NO
Patient is cleared for work (valid for one year).	☐ YES	☐ NO
Patient is referred to the Department of Public Health Communicable Disease Clinic for possible active tuberculosis ***(All required documents are attached).***	☐ YES	☐ NO

_____ Physician Signature/Stamp

_____ Name of Physician/Clinic

_____ Date