



TUBERCULIN SCREENING

Last Name		First Name	Middle Initial
Home Phone Number			
Facility	Job Title	Worksite	Work Number

Tuberculosis (TB) History

Have you ever had active tuberculosis? No Yes Year _____

Have you ever been treated for latent TB infection? No Yes Year _____

Have you ever had a positive TB skin test? No Yes Year _____

Have you ever had a chest X-ray for TB? No Yes Year _____

If yes or uncertain to any of the above, please explain & give dates (approximate): _____

Symptom Check (Check appropriate box and explain if yes)

Have you had a new unexplained cough for the last 3 weeks? No Yes Explain _____

Do you ever cough up blood? No Yes Explain _____

Have you experienced an unexplained weight loss of at least 10 pounds in the last 3-6 months? No Yes Explain _____

Do you have unexplained night sweats? No Yes Explain _____

Have you had unexplained fevers in the last 6 months? No Yes Explain _____

Have you been experiencing unusual fatigue? No Yes Explain _____

Voluntary Screening Program

I am hereby given the opportunity to be tested for tuberculosis, at no charge to me. An intradermal implantation of Purified Protein Derivative (PPD) will be required. Within 48 to 72 hours after implantation of each step, a health care provider must "read" the test. A positive reading will require follow-up by my health care provider.

I therefore choose to participate

I choose not to participate in the Department's voluntary TB screening.

Mandatory Screening Program

In compliance with DOC 890.610 Tuberculosis Program for Employees Contract Staff, and Volunteers, my position has been identified as high risk for occupational exposure to tuberculosis. I am therefore directed to receive a Tuberculin screening test, at no cost to me, before I am eligible to begin or continue working in this position. An intradermal implantation of Purified Protein Derivative (PPD) will be required. Within 48 to 72 hours after implantation of each step, a health care provider must "read" the test. A positive reading will require follow-up by my health care provider.

I therefore choose to participate

I choose not to participate in the skin testing, but will bring acceptable documentation to the Occupational Nurse Consultant within the next 7 days.

Employee/Contract Staff/Volunteer Signature	Date	Employee/Contract Staff/Volunteer Signature	Date
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FOR OFFICIAL MEDICAL USE ONLY

Reason for Testing: <input type="checkbox"/> Mandatory <input type="checkbox"/> Routine/Repeat <input type="checkbox"/> Voluntary	Reason for not Testing: <input type="checkbox"/> Document prior positive/History of TB <input type="checkbox"/> Not mandatory position <input type="checkbox"/> Other: explain _____
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Date Administered (1 step)	By (print)	Brand	Lot #	
Date Read	By (print)		PPD Results	mm
Date Administered (f/u)	By (print)	Brand	Lot #	
Date Read	By (print)		PPD Results	mm
Referred for Follow-up Appointment/X-Ray? <input type="checkbox"/> Yes <input type="checkbox"/> No, if yes, Where?			Date of Referral	
Nurse Signature			Date Signed	

The contents of this document may be eligible for public disclosure. Social Security Numbers are considered confidential information and will be redacted in the event of such a request. This form is governed by Executive Order 00-03, RCW 42.56, and RCW 40.14.

Distribution: **ORIGINAL** - Employee Occupational Health Record (EOHR)
COPY - Employee/Contract Staff/Volunteer