



## Employee Tuberculosis Surveillance Form

Patient's Name: \_\_\_\_\_

Patient's Date of Birth \_\_\_ / \_\_\_ / \_\_\_\_\_

Patient's SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Test Type	Date	Result
PPD/TB Skin Test	/ /	mm
CXR (for positive PPD/TB only)	/ /	

TB/PPD skin test is required each year. A Chest X-Ray (CXR) is required every five years for employees who have previously tested positive for TB.

Name of examiner: \_\_\_\_\_

Signature of examiner: \_\_\_\_\_

Title of examiner: \_\_\_\_\_

Facility Stamp

Please print and fax this completed form to our HR Department at 1-866-655-4347