



LAST NAME

FIRST NAME

DATE OF BIRTH

**TB SCREENING FORM**

*Only Choose One of These Options*

PPD Skin Test: Initial 2-Step	PPD Skin Test: Annual 1-Step*
PPD Skin Test: STEP 1 - Date Given: _____ PPD Skin Test: STEP 1 - Date Read: _____ Results: _____	PPD Skin Test: STEP 1 - Date Given: _____ PPD Skin Test: STEP 1 - Date Read: _____ Results: _____
_____ <b>Provider Signature</b> <span style="float: right;"><b>Date</b></span>	_____ <b>Provider Signature</b> <span style="float: right;"><b>Date</b></span>
PPD Skin Test: STEP 2 - Date Given: _____ PPD Skin Test: STEP 2 - Date Read: _____ Results: _____	<p><i>*The PPD 1-step is done annually <u>after</u> you have received the initial 2-step.</i></p>
_____ <b>Provider Signature</b> <span style="float: right;"><b>Date</b></span>	

TB Quantiferon	T-Spot TB Test
Date Collected: _____	Date Collected: _____
Date Recorded: _____	Date Recorded: _____
Results: _____ (Positive or Negative)	Results: _____ (Positive or Negative)
_____	_____
<b>Provider Signature</b> <span style="float: right;"><b>Date</b></span>	<b>Provider Signature</b> <span style="float: right;"><b>Date</b></span>

*Please use office stamp if available.*

**Provider Name:**

**Provider Address/City/State/Zip:**