

Tuberculosis Testing						
EMPLOYEE NAME			DATE OF BIRTH (MM/DD/YYYY)			
be implemented for all 6 3 weeks after initial ski	employees. If a TB s in test. The second available prior to assi	ng Medical Services, Inc. kin test is given with nega step should be placed in umption of job responsibil	tive res	sults, a second test must be posite arm of the first te	oe repeated within 1- st site. Negative test	
HAVE YOU HAD A POSITIV	E TB SKIN TEST REAC	CTION? ☐ YES ☐ NO				
TB ONE-STEP METHOD	DATE GIVEN	SITE ADMINISTERED	AD	MINISTERED BY (PRINT NAME)		
	DATE READ	RESULTS IN MM	RE	EAD BY (PRINT NAME)		
TB Two-Step Method	DATE GIVEN	SITE ADMINISTERED	AD	MINISTERED BY (PRINT NAME)		
	DATE READ	RESULTS IN MM	R	EAD BY (PRINT NAME)		
FACILITY NAME			TE	ELEPHONE NUMBER		
STREET ADDRESS			Сітү	STATE	ZIP CODE	
PHYSICAL EXAMINATION						
EMPLOYEE NAME						
		examined by me and fou ble to perform the essentia				
DATE OF PHYSICAL EXAM (MM/DD/YYYY)				WORK RESTRICTIONS ☐ NO ☐ YES, EXPLAIN		
PHYSICIAN'S SIGNATURE				DATE		
PHYSICIAN'S NAME PRINTED	YSICIAN'S NAME PRINTED TELEPHONE NUMBER					
STREET ADDRESS			Сітү	STATE	ZIP CODE	
EMPLOYEE'S SIGNATURE				DATE		