

TB/PPD STATUS

Name _____

Date _____

Please complete one of the following options

Option #1

TB/PPD Skin Test

_____ **Date**

_____ **result**

(Current within 12 mos)

COPIES OF TEST RESULTS MUST BE ATTACHED TO BE VALID

Option #2

Chest X-ray Report

_____ **Date**

_____ **Negative**

COPIES OF TEST RESULTS MUST BE ATTACHED TO BE VALID

If Positive TB skin test (PPD) Date: _____ Please complete Questionnaire

Please indicate if you are having any of the following problems for three to four weeks or longer:

Chronic Cough (greater than three weeks)	Yes	No
Production of Sputum	Yes	No
Blood-streaked Sputum	Yes	No
Unexpected Weight Loss	Yes	No
Fever	Yes	No
Fatigue/Tiredness	Yes	No
Night Sweats	Yes	No
Shortness of Breath	Yes	No

_____ **Date**

_____ **Employee Signature**