Employee Information

Full Name:	
Position/Title:	
Phone Number:	
Email Address:	
Date of Birth:	
Date of Hire:	

Section 1a: TB Test Appointment

Type of TB Test Requested: ☐ Skin Test (PPD) ☐ Quantiferon Gold (Blood Test)

Date Scheduled:	
Time:	
Location:	
Administered By (Clinic/Provider):	

Test Result:

Date Read:	
Result: ☐ Negative ☐ Positive Indeterminate	
Reviewed By (Healthcare Provider):	
Signature:	
Date:	

Section 1b: TB X-Ray Reading (if applicable)

☐ Chest X-Ray Required (due to positive TB Test or medical indication)

Date of X-Ray:	
Radiology Facility:	
X-Ray Result: ☐ Normal ☐ Abnormal	
Findings/Comments:	
Reviewed By (Radiologist/Provider):	
Signature:	
Date:	

Section 2: Medical Clearance

(To be completed by a licensed healthcare provider)

I have examined the above-named employee and reviewed the results of their TB Test and any other relevant medical history. Based on my evaluation:

☐ The individual is medically cleared for employment involving client care.

☐ The individual is not medically cleared for employment at this time.

Comments/Restrictions (if any): ____

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Provider Name:	
License Number:	
Clinic/Facility Name:	
Signature:	
Date:	
Phone:	