

**TB Skin Test (TST) Documentation**

*(If you are scheduled for your annual TB test, please use this form)*

Employee Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(please print)

Name of Location Performing TB Screening: \_\_\_\_\_

Phone Number of Location: \_\_\_\_\_

**Employee to Complete:**

1. Have you ever had a documented positive TB skin test?  No  Yes (Date: \_\_\_\_\_)

2. Have you ever had a documented significant skin ulceration and/or anaphylactic reaction to PPD?  No  Yes (Date: \_\_\_\_\_)  
If Yes to #1 or #2, please contact your Recruiter prior to receiving a TB Skin Test.

3. Have you ever received the BCG vaccine?  No  Yes (Date: \_\_\_\_\_)

4. Have you ever been treated for TB?  No  Yes (Date: \_\_\_\_\_)

5. I agree to return within 48-72 hours to have my TB Skin Test read.  Yes

Employee Signature: \_\_\_\_\_

**TB Administration:**

*Tuberculin Purified Protein Derivative (PPD)  
0.1mL administered intradermally (Mantoux Method):*

Administration Date: \_\_\_\_\_

Administration Time: \_\_\_\_\_ AM or PM?

Administered By: \_\_\_\_\_  
(Name/Credentials)

Site (circle one): Left Forearm      Right Forearm

This TB Skin Test Must be Read on:  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ or \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
(48 hours)                      (72 hours)

**TB Interpretation/Results:**

*(Must be read 48-72 hours from Administration Date/Time in order to be accepted)*

Read Date: \_\_\_\_\_

Read Time: \_\_\_\_\_ AM or PM?

Read By: \_\_\_\_\_  
(Name/Credentials)

Results: \_\_\_\_\_ millimeters (mm)  
of induration

Negative       Positive

Comments: \_\_\_\_\_  
\_\_\_\_\_

**FAX RESULTS BACK TO MEDICAL SOLUTIONS: 1-866-688-5929**