

Agency: _____
Phone: _____
Name _____
Address _____
Phone _____ Date of Birth _____
Date of TB Skin Test _____ Results _____ mm
Date of Chest X-Ray _____ Results _____
TB Preventive Therapy: Yes No
Treatment for Active Disease: Yes No
Medication(s) _____
Start Date _____ Completion Date _____
Address _____ Phone _____
Authorized Signature _____ Date _____

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