

TUBERCULOSIS 2 STEP SKIN TEST FORM

Please fax this form to your local office after each step is completed and reviewed. If you do not have the local office fax number, please contact the office directly to obtain it before sending.

Employee Name: _____

Date Placed: _____ Site: Right _____ Left: _____

Lot # _____ Expiration date: _____

Signature (Administered by)/Title: _____

Must be read within 48-72 hours from the date placed.

Date Read: _____ Induration (Please note mm): _____

PPD test result: _____ (Positive/Negative)

Signature (Administered by)/Title: _____

If the first test is negative, please administer a second tuberculosis test 7-21 days after the first one was completed.

Date Placed: _____ Site: Right _____ Left: _____

Lot # _____ Expiration date: _____

Signature (Administered by)/Title: _____

Must be read within 48-72 hours from the date placed.

Date Read: _____ Induration (Please note mm): _____

PPD test result: _____ (Positive/Negative)

Alternative Testing (if applicable)

QuantiFERON Blood Test Performed

Date Drawn: _____ Result: Positive Negative

Lab Name: _____

Medical Evaluation: If any result is positive, a chest X-ray and medical clearance are required before the employee begins work.

Final Medical Clearance: All tests are negative. Chest X-ray completed with no evidence of active TB.

The patient is **cleared to begin employment**

Signature (Medical Professional): _____ Date: _____

**Franchising Opportunities
Available**