



**TB Document F: State of Hawaii TB Clearance Form**  
 Hawaii State Department of Health  
 Tuberculosis Control Program

Patient Name	DOB	TB Screening Date

I have evaluated the individual named above using the process set out in the DOH TB Clearance Manual dated 2/10/17 and determined that the individual does not have TB disease as defined in section 11-164.2-2, Hawaii Administrative Rules.

<b>Screening for schools, child care facilities or food handlers (<i>TB Document A or E</i>)</b>
<input type="checkbox"/> Negative TB risk assessment
<input type="checkbox"/> Negative test for TB infection
<input type="checkbox"/> Positive test for TB infection, and negative chest X-ray

<b>Initial Screening for health care facilities or residential care settings (<i>TB Document B or C</i>)</b>
<input type="checkbox"/> Negative test for TB infection (2-step)
<input type="checkbox"/> New positive test for TB infection, and negative chest X-ray
<input type="checkbox"/> Previous positive test for TB infection, negative CXR within previous 12 months, and negative symptom screen
<input type="checkbox"/> Previous positive test for TB infection, and negative CXR

<b>Annual Screening for Health care facilities or residential care settings (<i>TB Document D</i>)</b>
<input type="checkbox"/> Negative test for TB infection
<input type="checkbox"/> New positive test for TB infection, and negative chest X-ray
<input type="checkbox"/> Previous positive test for TB infection, and negative symptoms screen
<input type="checkbox"/> Previous positive test for TB infection, and negative CXR

Signature or Unique Stamp of Practitioner: \_\_\_\_\_

Printed Name of Practitioner: \_\_\_\_\_

Healthcare Facility: \_\_\_\_\_

This TB clearance provides a reasonable assurance that the individual listed on this form was free from tuberculosis disease at the time of the exam. This form does not imply any guarantee or protection from future tuberculosis risk for the individual listed.