Certificate of TB (tuberculosis) Screening

		(Photo) 3.5㎝×4.5㎝
Name	Sex ☐ M ☐ F	※DRY SEAL BETWEEN PHOTO AND CERTIFICATE REQUIRED
Date of Birth	Phone Number	
Passport Number	Address	

I. Medical examination results

1. TB treatment history:

A. No ☐ B. Yes ☐ C. Under treatment ☐

2. Signs & Symptoms suggestive of TB: A. No ☐ B. Yes ☐

3. Date of Chest X-ray: _____/_____/_____(DD/MM/YYYY)

A. Normal ☐ B. Cured or Inactive TB ☐

C. Suspected active TB ☐

4. Date of sputum examination: _____/_____/_____(DD/MM/YYYY)

1) Sputum AFB smear: A. Negative) ☐ B. Positive ☐

2) Sputum *M. Tuberculosis* culture: A. Negative ☐ B. Positive ☐

3) TB PCR: A. Negative ☐ B. Positive ☐ C. Not done ☐

II. 결과(Interpretation)

1. No active TB ☐

2. Active TB or suspected TB ☐

The examination was performed as above

License No.: / Name of Physician: (signature)

Summary of the examination	
Remarks about examinee's travel abroad	
Additional close examination needed	* Attach doctor's opinion letter, if needed

We hereby certify that the examinee's heath status is assessed as above.

_____/_____/_____(DD/MM/YYYY)

(○○○○ Chief of Hospital) (signature)