



## STAFF HEALTH REPORT

### A. STAFF INFORMATION

Name (Last, First, MI)

Position Title

### B. TUBERCULOSIS TEST – MANTOUX Tuberculin Skin Test OR QuantiFERON Blood Assay for M. Tuberculosis

Date of Test (mm/dd/yyyy)

Risk Classification

Low risk    Medium risk    Potential ongoing transmission

Millimeters of Induration

5mm    10 mm    15mm

Positive    Negative

What were the results of the TB test?

Positive    Negative

If the results of the TB test were positive, what were the results of the follow-up medical evaluation?

Yes    No   Was a chest X-ray completed?

**SIGNATURE** – MD, PA or Health Check Provider

Name – Examining Health Professional (Type or Print)

Address – Health Professional Office (Street, City, State, Zip)

Date Signed (mm/dd/yyyy)

### C. PHYSICAL EXAMINATION

Yes    No I certify based upon my examination that this person appears free of symptoms of illness or communicable disease that may be transmitted through normal contact.

Yes    No I certify based upon my examination that this person appears to be physically able to work with clients.

Comments:

**SIGNATURE** – MD, PA or Health Check Provider

Name – Examining Health Professional (Type or Print)

Address – Health Professional Office (Street, City, State, Zip)

Date Signed (mm/dd/yyyy)