Above and Beyond Care HealthSystem (Agency)

Health Attestation Form

Employee Name: _____

Date of First Case: _____ (first day worked)

Action Completed	**Dates**	**Signature/Title**
☐ Post-Offer Health Assessment	_____	_____
☐ **Initial TB Screening**	_____	_____
☐ IGRA blood test *OR*	_____	_____
☐ 1-step Mantoux Screening	___ /____	_____
OR		
☐ Date of chest x-ray	_____	_____
☐ Date of TB questionnaire	_____	_____
☐ Annual TB Screening Questionnaire	_____	_____
☐ Hepatitis B Vaccine: date accepted/declined	_____	_____
☐ Influenza Vaccine (if warranted)	_____	_____
☐ Periodic Physicals (if required by agency)	_____	_____

Designated Reviewer

I attest that the above information is truthful and correct pursuant to my review of the health records for the above employee.

Name (Print):_____ Title:_____

Signature:_____ Date:_____

Name (Print):_____ Title:_____

Signature:_____ Date:_____

Name (Print):_____ Title:_____

Signature:_____ Date:_____

Above and Beyond Care HealthSystem (Agency)
Alternate Assessment - TB Screening Questionnaire

Employee Name: _____

This form is completed annually for those employees who have documentation of a negative chest X-ray following a positive Mantoux screening test, and whose medical evaluation and chest X-ray indicate that no further Mantoux screening is required.

Do you experience any of the following:	Yes	No
• bad cough that lasts longer than two (2) weeks	☐	☐
• coughing up sputum (phlegm)	☐	☐
• coughing up blood	☐	☐
• loss of appetite	☐	☐
• weakness/fatigue/tiredness	☐	☐
• night sweats	☐	☐
• unexplained weight loss	☐	☐
• fever	☐	☐
• chills	☐	☐
• chest pain	☐	☐

Have you recently spent time with someone who has infectious tuberculosis? ☐ Yes ☐ No

Foreign born person from or recent traveler to high-prevalence area of TB? ☐ Yes ☐ No

Chest X-Ray with impression findings suggestive of LTBI or past TB? ☐ Yes ☐ No

Have you been told that you have low T4 cell count due to infection? ☐ Yes ☐ No

Are you an organ transplant recipient within last year? ☐ Yes ☐ No

Resident or employee of high-risk congregate setting (LTCF, Hospital) ☐ Yes ☐ No

Were you told in the last year that you may have Immunosuppression due to medication or a chronic disease ☐ Yes ☐ No

Any other complaints? ☐ Yes ☐ No

If yes, explain:_____

_____

The above health statements are accurate to the best of my knowledge. I have been in-serviced on the signs and symptoms of tuberculosis and been advised to seek medical care if any of the symptoms develop at any time.

Employee Name (print): _____ Title: _____.

Employee Signature: _____ Date: ____/____/_____.

Nurse Reviewer Recommendation

☐ Refer employee TB/LTBI screening before continuing work.

☐ Refer employee for medical evaluation immediately, before continuing work.

☐ No action to be taken at this time.

RN Name (print): _____ Title: _____

RN Signature: _____ Date: ____/____/_____

Date Implemented: 08/01/2022_

Date Revised: ____/____/_____