

# ADULT TUBERCULOSIS SCREENING CERTIFICATE

1. Does applicant have any of the following symptoms?
 

<input type="checkbox"/> Cough > 3 weeks	<input type="checkbox"/> Night sweats
<input type="checkbox"/> Unexplained fever	<input type="checkbox"/> Unexplained weight loss

If **no**, go to #2

If **yes**, stop here and evaluate for active Tuberculosis. Proceed to #2 when active TB ruled out.
2. Has applicant had a prior documented **positive** TB skin test (TST)?
  - If **No**, go to #3.
  - If **Yes**, but no X-ray documentation, refer for chest x-ray and evaluate.
  - If **Yes**, and X-ray results documented and abnormal, evaluate for possible active TB. Sign below when active TB ruled out.
  - If **Yes**, and X-ray results documented and normal, sign this certificate below.
3. Ask **all** the following risk assessment questions and check if "yes" since the applicant's last documented negative TST or last negative risk assessment.
  - a.  Was the individual born in a high risk country\* and been in the US for fewer than 5 years?
  - b.  During the past two (2) years, did the individual live more than three (3) months in a high risk country\*?
  - c.  Has the individual been in close contact with a person known to have active tuberculosis?
  - d.  Has the individual worked in or been a resident in a congregate living setting such as a shelter, prison, jail, nursing home or assisted living facility?
  - e.  Has the individual injected illicit drugs?

**CDC Classification of Positive TST Reaction**

≥5mm: HIV+ persons, recent contacts of TB case, patients with organ transplant, and other immunosuppressed patients

≥10mm: anyone else with positive response to the risk questions above

If **no** to 3 a through e, sign this certificate below now.

If any one answer is **yes**, plant a TST and read the results at 48 to 72 hours.

If the TST is **negative**, sign this certificate below.

If the TST is **positive** (see box), evaluate as usual.

*\*High Risk Countries=countries other than the US, Canada, Australia, New Zealand, or in Western Europe*

Clip along dotted line and give portion below to applicant.



## CERTIFICATE OF TB SCREENING

Name of applicant: \_\_\_\_\_ ID/DOB \_\_\_\_\_

This certifies that the screening is complete and that the applicant is free of communicable TB disease.

\_\_\_\_\_  
Physician's or RN's signature

\_\_\_\_\_  
Print Full Name

\_\_\_\_\_  
Date

<p><b>If applying for position at Arlington Public Schools, answer the following:</b></p> <p>Hiring work location: _____</p> <p>Job Title: _____</p> <p>Phone #: _____</p> <p><i>Minors must attach "Parental Consent for Occupational Health Evaluation and Deemed Consent" form.</i></p>	<p><b>Physician or Health Dept. must print or sign here:</b></p> <p>Name Of Facility: _____</p> <p>Doctor's Name: _____</p> <p>Address: _____</p> <p>_____</p> <p>Phone #: _____</p> <p>Fax #: _____</p>
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