

ANNUAL PHYSICAL EXAMINATION

Name: _____

Date: _____

TB Screening

TB Skin Test: Date given _____ Date read _____ Results _____

QuantiFERON TB Gold Test: Date drawn: _____ Results _____

Chest x-ray: Date given _____ Results _____

TB Fit Test: Mask Size _____

General Comments:

The above-named individual has been examined by me and is free from symptoms indicating the presence of an infectious disease and does not have any condition, which would interfere with the performance of his/her duties as a health care professional.

Primary Care Provider's Name

Primary Care Provider's Signature

Date

Address: _____

Telephone Number: _____

Physician ID #: _____