Registry Network
Incorporated

ANNUAL PHYSICAL EXAMINATION

Name: _____

Date: _____

TB Screening

TB Skin Test: Date placed _____Time _____ Date read _____ Time_____ Results ___ MM

QuantiFERON TB Gold Test: Date drawn: _____ Results _____
Lab results must be submitted

Chest x-ray: Date given _____ Results _____
Report must be submitted

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 #: _____

Revised 8/7/18