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 #: ___________________________

Form Updated 10/29/2020