

**CONFIDENTIAL EMPLOYEE MEDICAL INFORMATION**

INSTRUCTIONS: Tuberculosis (TB) screening must be performed by a licensed health care provider whose legally authorized scope of practice allows him/her to conduct medical examinations and/or the Mantoux TB Skin Test (TST) in accordance with the recommendations of the Centers for Disease Control and Prevention to determine if a person has TB infection or disease.

**EMPLOYEE (Complete the following section type or print clearly)**

<b>1</b>			<b>EMPLOYEE INFORMATION</b>		
PRINT OR TYPE EMPLOYEE'S FULL NAME (AS IT APPEARS ON STATE PAYCHECK) FIRST MI LAST			GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
BIRTHDATE		LAST 6 DIGITS OF SOCIAL SECURITY NUMBER		NEW EMPLOYEE/CADET <input type="checkbox"/> YES <input type="checkbox"/> NO	
INSTITUTION OR DIVISION		UNIT OR BRANCH		DEPARTMENT (IF NOT CDCR)	
EMPLOYEE SIGNATURE			DATE		

**HEALTH CARE PROVIDER (Complete Sections 206 as required refer to instructions)**

<b>2</b>			<b>PRIOR TST/TB HISTORY (AS DOCUMENTED IN THE EMPLOYEE HEALTH CARE RECORD)</b>		
<b>NOTE: PRIVATE PROVIDERS ATTACH DOCUMENTATION OF PRIOR HISTORY</b>					
PRIOR SIGNIFICANT TB SKIN TEST/INFECTION <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, DATE: _____ INDURATION SIZE: _____ MM		PRIOR TB DISEASE <input type="checkbox"/> YES <input type="checkbox"/> NO	

**NOTICE: HIV AND OTHER MEDICAL CONDITIONS MAY CAUSE A TST TO BE NEGATIVE WHEN TB INFECTION IS PRESENT**

<b>3</b>						<b>TST ADMINISTRATION (5 TU/0.1 milliliter)</b>					
(CHECK ONE) <input type="checkbox"/> TUBERSOL <input type="checkbox"/> APILSOL		LOT NUMBER _____		EXPIRATION DATE _____		TST ADMINISTERED BY (PRINT NAME)		SIGNATURE _____		DATE _____	
INJECTION SITE <input type="checkbox"/> LFA* <input type="checkbox"/> RFA**		INJECTION DATE _____		INTERPRETATION _____		TST RESULT (M INDURATION)		DATE TST READ/OR OF SIGN & SYMPTOM EVALUATION			
<b>4</b>						<b>EVALUATION FOR SIGNS AND SYMPTOMS (MUST BE COMPLETED FOR ALL INDIVIDUALS)</b>					
<input type="checkbox"/> NO SYMPTOMS		SYMPTOMS (CHECK ALL THAT APPLY)		<input type="checkbox"/> WEIGHT LOSS (UNEXPLAINED)		<input type="checkbox"/> UNEXPLAINED FATIGUE		<input type="checkbox"/> UNEXPLAINED NIGHT SWEATS		<input type="checkbox"/> UNEXPLAINED FEVER	
<b>5</b>						<b>CHEST XRAY</b>					
<input type="checkbox"/> CHEST XRAY NEEDED			<input type="checkbox"/> CHEST XRAY REPORT ON FILE (COPY REQUIRED)			CHEST XRAY RESULT <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL		CONSISTENT W/TB <input type="checkbox"/> YES <input type="checkbox"/> NO			
<b>6</b>						<b>COMMENTS</b>					
<input type="checkbox"/> EMPLOYEE REFERRED FOR FOLLOWUP MEDICAL EVALUATION						<input type="checkbox"/> EMPLOYEE PROVIDED WRITTEN NOTIFICATION OF TST RESULTS					
<input type="checkbox"/> NO SHOW EMPLOYEE NOTIFIED						<input type="checkbox"/> EMPLOYEE IS FREE OF INFECTIOUS TUBERCULOSIS					
EVALUATOR NAME				EVALUATOR SIGNATURE				DATE			

\*LFA: LEFT FOREARM  
 \*\*RFA: RIGHT FOREARM

**NOTICE TO PRIVATE PHYSICIANS ON NEXT PAGE  
 PLEASE READ PRIOR TO TESTING**