UNIVERSITY OF MIAMI, EMPLOYEE HEALTH
TUBERCULOSIS SCREENING & TESTING FORM

Print last name, first, middle initial _____ Date of birth _____ C# _____

Department Building and Room # _____ Work phone # _____ Supervisor _____

Home Address, Street _____ City _____ Zip Code _____ (_____) Telephone # _____

1. Do you have a history of positive TB skin test? _____ When? _____
2. Have you ever taken medications for TB? _____
3. In what Country were you born? _____
4. BCG is a vaccine for TB. Were you BCG vaccinated? _____ When? _____
5. Do you have direct contact with Patients? _____
6. Do you have a weak immune system? _____
7. Have you had a chest xray in the past 6 months? _____
8. Was it normal? _____
9. Do you have any of the following symptoms?

Persistent cough (greater than two weeks)	Yes _____	No _____
Unexplained weight loss	Yes _____	No _____
Unexplained loss of appetite	Yes _____	No _____
Frequent low-grade fevers	Yes _____	No _____
Night sweats	Yes _____	No _____
Frequent chills	Yes _____	No _____
Frequent fatigue	Yes _____	No _____

10. Allergies: _____
11. _____ I consent to be tested for tuberculosis. I will return at the designated time to have the test read. I understand that failure to return may result in disciplinary action.
12. _____ I decline to be tested secondary to a previous positive skin test. I understand I may be required to obtain a chest xray at no expense to myself.
13. Do you have animal contact at work? Yes _____ No _____
14. If Yes, Name of Species _____
15. Employee signature _____ Date _____

Do not write below this line

Date Placed _____ **Results** _____ **Induration** _____ **Chest Xray Ordered** _____

Angery Testing _____ **XrayResults** _____

Medication prescribed _____

(2- Step testing) ❑ Yes ❑ No PPD - Lot # _____ **Manufacturer name** _____ **Exp. date** _____

Dose (0.1-ml Route - Intradermally ❑ _____

Comments _____

Is this result considered a conversion _____

Health Care Provider signature _____ **Date** _____

Rev. 10/01

White EHS

Attach this form to the TB screening form.

UHealth
UNIVERSITY OF MIAMI HEALTH SYSTEM
UNIVERSITY OF MIAMI EMPLOYEE HEALTH OFFICE
ENVIRONMENTAL HEALTH AND SAFETY DEPARTMENT
1400 NW 10TH AVENUE, SUITE 405 (R-23)
MIAMI, FL 33136
TELEPHONE: (305) 243-3267 FAX: (305) 243-2393

TUBERCULOSIS SCREENING AND TESTING REPORTING FORM

(For Departmental Records)

LAST NAME: _____ FIRST NAME: _____

UM ID#: _____

DEPARTMENT: _____

OFFICE USE ONLY

DATE CLEARED (READING DATE): _____

EHO STAFF SIGNATURE: _____

OFFICE OF
ENVIRONMENTAL HEALTH & SAFETY (R-23)
SUITE 405 DOMINION TOWER
1400 NW 10TH AVE
MIAMI, FL 33136
MEDICAL CAMPUS