UNIVERSITY OF MIAMI, EMPLOYEE HEALTH
TUBERCULOSIS SCREENING & TESTING FORM

Print last name, first, middle initial
Department Building and Room #
Home Address, Street City Zip Code
Date of birth C#
Work phone # Supervisor (_______)
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

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.

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
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MIAMI, FL 33136
MEDICAL CAMPUS

TSTRF/EA 8/13