Please have a health care professional complete one of the below options indicating your current status:

MANDATORY TUBERCULOSIS SKIN TEST (TST)

Name (Please Print)

Banner Number

Signature of Healthcare Professional or Public Health Official

Date

Phone Number

A No Record of Previous 2 Step TST

Provide Dates & Results of 2 Step TST below:

	Dates Planted		Dates Read	
Step 1	DD/MM/YY	1st Date	DD/MM/YY
		Results	
Step 2	DD/MM/YY	2nd Date	DD/MM/YY
		Results	

B Record of Previous 2 Step TST *Within Last 12 Months*

Attach Documentation of the previous 2 step TST with dates and results:

Documentation Attached (Y/N) ☐

C Record of Previous 2 Step TST *More Then 12 Months Ago*

1 Step TST & Documentation of the previous 2 step TST:

Date Planted	DD/MM/YY		
Date Read	DD/MM/YY	Results	

Documentation Attached (Y/N) ☐

E Positive TST (Do not repeat test)

Chest x-ray required for the following:

- ☐ Documented prior positive TST
- ☐ Previous Treatment for active TB
- ☐ Previous Treatment for latent TB

Date	DD/MM/YY	Results	

Documentation Attached (Y/N) ☐

F TST Contraindicated

Contraindications to TST include:

- ☐ History of severe blistering or Anaphylaxis from TST
- ☐ Previous Positive TST (See Choice E)
- ☐ Severe active viral infection
- ☐ Received a live virus vaccination in the past month (MMR)
- ☐ Other

If there is a contraindication to TST such as a documented prior positive TST, previous treatment for active TB, or previous treatment for latent TB (See list above for more contraindications), a TST is not required—Medical evaluation and chest X-ray within 1 year are required.

Please note: A prior BCG is not a contraindication. *If a BCG has been administered in the past, please follow options A, B, or C*

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