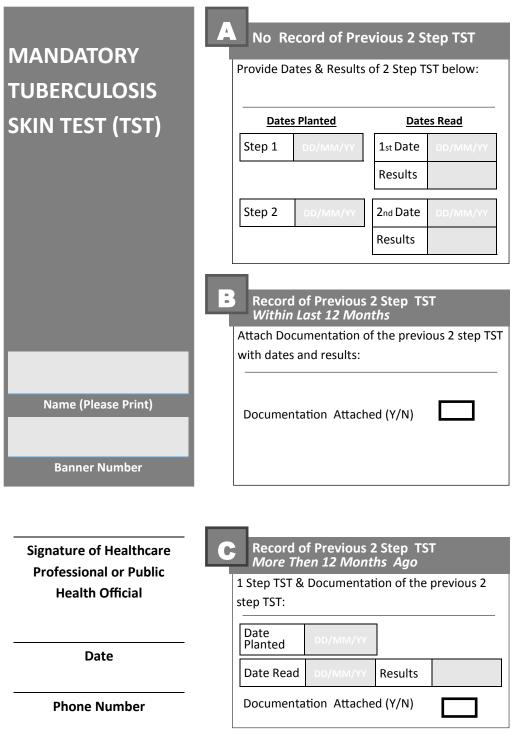
Please have a health care professional complete one of the below options indicating your current status:



Criest x-ray	required for t	he followi	ng:
□ Doc	ımented prioi	positive T	ST
□ Prev	ious Treatme	nt for activ	re TB
□ Prev	ious Treatme	nt for later	nt TB
			I
Date	DD/MM/YY	Results	

3	TST Contraindicated
Con	traindications 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
doc trea late con eval	nere is a contraindication to TST such as a umented prior positive TST, previous them the for active TB, or previous treatment for nt TB (See list above for more traindications), a TST is not required—Medical luation and chest X-ray within 1 year are uired.

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

