True Vision Staffing, Inc.

TB TEST RESULTS FORM

Name: ___________________________________

DOB: ____________________

The following must be completed by a physician's office:

Must be completed within 12 months prior to the start of classes.

Date given: ___/___/___ Date read: ___/___/___

Result: _____mm (record in actual mm of induration. If no induration, write "0')

Interpretation (based on mm of induration as well as risk factor(s):

Positive___ Negative___

OR – T-spot lab test ___

Must be completed within 12 months prior to the start of classes.

Date of test: ___/___/___ Result: ___/___/___

If either TB skin test or T-spot lab test are positive, then a chest x-ray is required:

Chest x-ray results: Normal ________ Abnormal _________

Date of chest x-ray: ___/___/___

____ _________________________

Physician or Nurse Signature Date

____

Official Office Stamp

*Note: Your physician's office may use its own TB test form to report results, or you may be submitting results from a TB test administered within the last 12 months. If so, please attach that documentation. Please indicate dates when the test was administered and read.