Tuberculosis Skin Test Form

Employee/Candidate Name: ________________________________ Date Of Birth: ______________

Testing Facility Name: ____ City: ________________

Testing Facility Address:____ State:________________

Employee/Candidate signature: _______________________________ Date:____________________

ADMINISTRATION

Date of Test :_____________________ Site: Left Arm: ______ Right Arm: _______

Lot#:____________________________ Expiration Date:__________________________

Administered By-Signature:_________________________________ Title:_____________________

READING

Date Read (Within 48-72 hours from date placed)

Induration (please note in mm):_________________________ mm

PPD (Mantoux) Test Result: Negative:_________________ Positive:__________________

Results Read by-Signature:_________________________________ Title:_____________________

***In order for this document to be valid/acceptable, all sections of this form must be completed.**

Please fax results to 512-218-0904 or 866-289-3893

Thank you for your time and assistance.

Nursing Group
Ph: 512-388-0123
Fax: 512-218-0904
www.nursinggroup.com