Annual Mantoux (TB) Report Form

Name:		**Birthdate:**
Address:		**County of Service:**
		Position Applied for:
Telephone:	( )	

Signature of Employee _____ **Date** _____

MANTOUX (TB) SCREENING

Date Given	Date Read	Interpretation	Signature/Title (MD,PA,RN,LPN,NP)
		mm	

If you believe this individual should be exempt from a Mantoux test for medical reasons, please indicate why and if you would recommend this test at a later date: _____

_____

_____

☐ This individual does not show symptoms of active tuberculosis. I do not have any recommendations for further testing at this time.

☐ This individual shows symptoms indicating suspected or active tuberculosis disease and is under my care. The individual will not be permitted to work until the Agency receives a note from me stating that the conditions outlined below have been met. Recommended course of action will include:

_____

_____

Examiner (Print Name): (MD,PA,RN,LPN,NP) _____

Address: _____

Date of Exam: _____

Telephone: ( ) _____

Return to:

The Resource Center for Independent Living
Attn: Human Resource Dept. Confidential
409 Columbia Street, PO Box 210 Utica, NY 13503

Phone 315- 797- 4642
Fax 315- 797- 4747

Revised 1/11