Employees/Volunteers are REQUIRED to be screened for tuberculosis (Tb) prior to your start date. If available, please provide documentation of previous Tb testing documentation. If you have a history of a positive Tb skin test, you may be sent for a blood test and/or receive a chest x-ray unless proper evidence of Tb screening is presented. In addition, for those with a positive screening history please review the symptoms of Tb highlighted in the last paragraph and sign below.

Please bring this form to Occupational Health (see above) on Mondays, Tuesdays, Wednesdays or Fridays (not on Thursdays) between 8 a.m.-12 p.m. or 2 p.m. and PRIOR to 3:30 p.m. for the test. Please anticipate 2 or more additional visits for evaluation and administration with the dates to be determined. If you fail to return for the reading, you may need to have the test repeated.

*****INFORMATION BELOW TO BE COMPLETED BY EHS MEDICAL PERSONNEL *****

<table>
<thead>
<tr>
<th>NKDA</th>
<th>Allergy</th>
<th>No Hx of +TST</th>
<th>No Immuno/Medical Compromise</th>
<th>No Hx of Latex sensitivity/allergy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>(To be performed 1-3 weeks after first test and only if first test is negative/not positive)</td>
<td></td>
</tr>
</tbody>
</table>

If yes, reviewed latex form _______ (initial)

<table>
<thead>
<tr>
<th>Administration Date:</th>
<th>CPRS</th>
<th>Administration Date:</th>
<th>CPRS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lot #:</td>
<td></td>
<td>Exp.</td>
<td></td>
</tr>
<tr>
<td>Mfr.</td>
<td></td>
<td>Exp.</td>
<td></td>
</tr>
<tr>
<td>0.10cc L or R forearm ID ( circle L or R )</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date Test Read: ____________ CPRS

Result: Negative: _______ (_____) mm of induration

Not Positive: _______ (_____) mm of induration

Positive: _______ (_____) mm of induration

Indeterminate: ____________

Titled Signature: ____________

Date Test Read: ____________ CPRS

Result: Negative: _______ (_____) mm of induration

Not Positive: _______ (_____) mm of induration

Positive: _______ (_____) mm of induration

Indeterminate: ____________

Titled Signature: ____________

Quantiferon T-spot Test ordered/reviewed (circle one) Results Reviewed

Date: ____________

Result: ____________

If positive, will need chest x-ray

** POSITIVE results/history of the following tests will require a chest x-ray:

- TST
- Quantiferon
- T-spot Test

Chest x-ray Date: ____________

Chest x-ray Results: ____________

Results Reviewed: ____________

Titled Signature: ____________

****FOR THOSE WITH A POSITIVE TB SKIN TEST HISTORY ****

If you have had a positive Tb screening in the past and are NOT experiencing any Tb symptoms such as persistent cough, night sweats, coughing up blood, malaise or weight loss, please sign below.

Signature: ____________ Date: ____________

FOR OHS PERSONNEL ONLY: Clearance Form to Voluntary Services via VOLUNTEER or I/O MAIL.