Spring 2019 FTTA TB Screening Form

1. To be completed by medical practitioner administering/reading the TB test.
2. The clinic, doctor's office or the applicant should either fax this form to (714) 991-8537 or email it to medicalreview@ftta.org.

**Application will not be processed until this form is received*

Name ________________________________ Gender _____ Date of birth ____________

(The name on this form must be the same as the legal name on the FTTA application.)

CHECK ONE OF THE FOLLOWING FOUR OPTIONS:

______Submit documentation, in English, of a *negative PPD* performed after August 17, 2018.

Date of PPD placement__________

Date of PPD reading____________

Result (circle one): Negative or Positive Diameter of reading_____________

______Submit documentation, in English, of a *negative Quantiferon* or *T-Spot.* TB blood test performed after August 17, 2018.

Qualitative test interpretation____________________________

Quantitative assay measurement__________________________

______Submit the report of a *chest x-ray*, in English, signed by a radiologist, with no evidence of active tuberculosis performed after February 17, 2018. Include a copy of the chest x-ray in electronic format. (If the chest x-ray is unavailable in electronic format, a film copy of the chest x-ray may be submitted by the first day of the training.)

______Submit documentation, in English, of a completed *course of treatment or prophylactic treatment* of tuberculosis.

Was the treatment curative or prophylactic?____________________

If curative, date of negative AFB smear_______________________

Medications used____

Date treatment was begun_________________________________

Date treatment was completed______________________________

Signed ______________________________ Professional title______ Date__________

Address ____

Phone ______________________________

Fax ______________________________

Clinic/Physician's Office Stamp