PPD/HEPATITIS B FORM

Family Choice Healthcare requires all applicants/employees to submit to **ANNUAL** TB testing, unless otherwise indicated by a licensed Physician/Nurse Practitioner. **It is also highly recommended that all clinical employees received the Hepatitis B vaccine.**

This form must be completed by your Health Provider and returned to Family Choice Health Care ***before*** placement and as a condition of continued employment.

If you have any questions, you may contact our office at 888.358.1341 ext.103.

_____ _____

Applicant/Employee Name ***Date***

TO BE COMPLETED BY EXAMINING HEALTH PROVIDER ONLY

Name of Provider_____

Office Address_____

Telephone No._____

TUBERCULIN TESTING

TYPE OF TEST 1: **MANTOUX**_____ **INJECTOR**_____

Lot #_____ **Exp. Date**_____

DATE TESTED: _____/_____/_____ TESTED BY:_____

RESULTS (In mm) _____ READ BY:_____DATE READ:___/___/_____

TYPE OF TEST 2: **MANTOUX**_____ **INJECTOR**_____

Lot #_____ **Exp. Date**_____

DATE TESTED: _____/_____/_____ TESTED BY:_____

RESULTS (In mm) _____ READ BY:_____DATE READ:___/___/_____

Which tests were done to verify the individual is free from active TB?

- ❑ PPD
- ❑ CHEST X-RAY:

DATE_____ **RESULT**_____

HEPATITIS B:

#1_____ **#2**_____ **#3**_____
(Date) **(Date)** **(Date)**

- ❑ **Declined by Employee:** _____
(Employee Signature)

PROVIDER SIGNATURE_____ **DATE**_____
(TITLE)