PPD/HEPATITIS B FORM

Family Choice Health Care requires annual TB testing, unless otherwise indicated by a licensed Physician/Nurse Practitioner. It is also highly recommended that all clinical employees receive the Hepatitis B vaccine.

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

If you have any questions, please call 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

TEST #1: **MANTOUX**_____ **INJECTOR**_____**Lot #**_____ **Exp. Date**_____

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

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

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?

- ❑ T-SPOT **DATE:**_____ **RESULT**_____
- ❑ CHEST X-RAY: **DATE**_____ **RESULT**_____

HEPATITIS B

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

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

PROVIDER SIGNATURE_____ **DATE**_____