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 267.202.1164.

______________________________________ ________________________

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**________________