

**TB FORM**

\_\_\_\_\_ was given a TB test on \_\_\_\_\_.  
( Client Name) (Date)

TB test was read on \_\_\_\_\_.  
(Date) Arm \_\_\_\_\_ left/right

Circle outcome of results: Negative \_\_\_\_\_ Positive \_\_\_\_\_

Administered by: \_\_\_\_\_ Date: \_\_\_\_\_  
Name/Title

Examiner: \_\_\_\_\_ Date: \_\_\_\_\_  
Name/Title

If test is positive, please contact Medical Director.

Action Taken if positive:

---

---

---

---