

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:
