TUBERCULOSIS SCREENING FORM

Last Name: _____________________     First Name: ________________________
Date of Birth: ___ / ___/ _______           Department: _______________________

This form is to be completed by all employees, volunteers, students and others who:

- Are New Texas Tech employees and do NOT work in "High Risk" clinics.
  (Internal Medicine and Family Medicine clinics are considered “High Risk”).
- Have or have had a positive TB skin test (TST)
- Have had treated active TB

Have you had any of the following symptoms for more than three weeks at a time?

☐ No symptoms
☐ Persistent Cough         ☐ Blood-tinged sputum when you cough
☐ Unexplained fever        ☐ Unexplained weight loss
☐ Unexplained night sweats ☐ Unexplained general fatigue

To the best of my knowledge, the above statements are correct and complete and may be used to whatever extent necessary in connection with employment or other Texas Tech activity.

Fax completed form to Occupational Health Services (915) 545-6680.

___________________________       _________________________      ______________
Print Name                                            Signature                                                Today’s Date