



Tuberculosis Screening

Please Note:

@WORK Medical Services requires all employees to supply proof of this screening annually. (We accept alternate physician statement forms if they include the information as required below.)

First, Middle, Last Name (as appears on identification)

PLEASE ATTACH COPIES OF ALL TEST RESULTS

Type	Date	Results
TB/PPD Skin Test:		
Mantoux I		
Mantoux II		
OR		
Chest X-Ray		

The above named individual has been screened by me and documentation is enclosed.

 Physician Name Physician Signature Date

 License Number Address

 Phone Number Please fax completed statement to: _____