Department of Corrections
WASHINGTON STATE

TUBERCULIN SCREENING

Last name	First name	Middle initial	Home phone number

Job title	Worksite/Facility	Work number

TUBERCULOSIS (TB) HISTORY

Have you ever had active tuberculosis? ☐ No ☐ Yes Year _____
Have you ever been treated for latent TB infection? ☐ No ☐ Yes Year _____
Have you ever had a positive TB skin test? ☐ No ☐ Yes Year _____
Have you ever had a chest X-ray for TB? ☐ No ☐ Yes Year _____

If yes or uncertain to any of the above, please explain and give dates (approximate):

_____

SYMPTOM CHECK (Check appropriate box and explain if yes)

Have you had a new unexplained cough for the last 3 weeks? ☐ No ☐ Yes Explain _____
Do you ever cough up blood? ☐ No ☐ Yes Explain _____
Have you experienced an unexplained weight loss of at least 10 pounds in the last 3-6 months? ☐ No ☐ Yes Explain _____
Do you have unexplained night sweats? ☐ No ☐ Yes Explain _____
Have you had unexplained fevers in the last 6 months? ☐ No ☐ Yes Explain _____
Have you been experiencing unusual fatigue? ☐ No ☐ Yes Explain _____

COVID-19 VACCINE

Have you received a COVID-19 vaccine? ☐ No ☐ Yes

Date administered (#1)	Date administered (#2)	Manufacturer (Pfizer/Moderna/J&J-Janssen/other)

☐ **Voluntary Screening Program**

I am hereby given the opportunity to be tested for tuberculosis at no charge to me. An intradermal implantation of Purified Protein Derivative (PPD) will be required. Within 48 to 72 hours after implantation of each step, a health care provider must "read" the test. A positive reading will require follow-up by my health care provider.

☐ I therefore choose to participate
☐ I choose not to participate in the Department's voluntary TB screening.

☐ **Mandatory Screening Program**

In compliance with DOC 890.610 Tuberculosis Program for Employees Contract Staff, and Volunteers, my position has been identified as high risk for occupational exposure to tuberculosis. I am therefore directed to receive a Tuberculin screening test, at no cost to me, before I am eligible to begin or continue working in this position. An intradermal implantation of Purified Protein Derivative (PPD) will be required. Within 48 to 72 hours after implantation of each step, a health care provider must "read" the test. A positive reading will require follow-up by my health care provider.

☐ I therefore choose to participate
☐ I choose not to participate in the skin testing, but will bring acceptable documentation to the Occupational Nurse Consultant within the next 7 days.

_____ _____ _____ _____
Employee/Contract staff/Volunteer signature Date Employee/Contract staff/Volunteer signature Date

FOR OFFICIAL MEDICAL USE ONLY

Reason for testing: ☐ Mandatory ☐ Routine/repeat ☐ Voluntary
Reason for not testing: ☐ Not mandatory position ☐ Document prior positive/history of TB ☐ Other (Explain): _____

Date administered (1 step)	By (print)	Brand	Lot #		
Date read	By (print)		PPD results		mm
Date administered (f/u)	By (print)	Brand	Lot #		
Date read	By (print)		PPD results		mm
Referred for follow-up appointment/x-ray? ☐ Yes ☐ No If yes, where?			Date of referral		
Nurse signature		Date signed			

The contents of this document may be eligible for public disclosure. Social Security Numbers are considered confidential information and will be redacted in the event of such a request. This form is governed by Executive Order 16-01, RCW 42.56, and RCW 40.14.

Distribution: **ORIGINAL** - Employee Occupational Health Record (EOHR) **COPY** - Employee/Contract staff/Volunteer