PPD SCREENING
(This form should be completed by your health care provider)

Name of applicant: _____________________________________  Date: ________________

Provide documentation of PPD testing within the past 12 months:

Date: ___________________________  PPD Result: _______________ mm

If PPD positive, document:

1) Date of positive PPD testing: _____________________________________

2) Treatment: _________________________  Dates: ___ _______________________

3) Chest X-Ray: __________________________________    Dates: ___________________

Results within past 24 months

__________________ ____________________________   ________________

Screening Practitioner’s Name (Print)      Date

________________________ ______________________

Screening Practitioner’s Signature

If you received the BCG Vaccine or if you have previously had a positive PPD test but have not had a chest x-ray within the past 24 months, please respond below:

Are you currently experiencing any of the following symptoms:

- Fever    □     Yes    □     No
- Cough     □     □
- Recent Weight Loss □     □
- Hemoptysis □     □

________________________________
Applicant’s Signature