

**Organization:**

**Address:**

**TB Test report**

**Name:**

**Address:**

**Select one from the options below: (Strike off whatever is not applicable)**

**Intra-dermal TB test:**

**Chest X-Ray:**

**Date:**

**Results:**

**Signature:**

**Physician:** \_\_\_\_\_ **Asst Physician:** \_\_\_\_\_ **Nurse :** \_\_\_\_\_ **Others:** \_\_\_\_\_