Yearly One Step TB Test Requirement Form

In order to attend your clinical placement, you must provide proof of your tuberculosis (TB) status prior to placement.

- If your previous TB test was **NEGATIVE:** please complete Part B below with your current 1 step TB test. TB tests are valid for 1 year.
- If your previous TB test was **POSITIVE:** please complete Part C below with your physician. Attach your chest X-ray report. This may be a new chest x-ray or your original chest x-ray dependent on your physician's assessment. Repeat TB testing is not recommended.

TB testing can be completed by your family physician, at the Campus Health Centre or the Public Health Department. You may be required to pay a fee for the test.

All information must be transcribed to this form. Supporting documents alone will not be accepted.

Part A: Personal Information (to be completed by student):

Last Name: __________________________ First Name: ________________________

Student ID#: __________________________ Program: __________________________

Date of previous Tuberculin Test: _________________ Result: _______________mm

Part B: Yearly 1 Step TB Test (to be completed by healthcare provider):

One-step TB test (read 48-72 hours after planting)

Date given: ___________________ Date read: __________________

Site R/L forearm result _______________mm

Part C: Assessment for past or current positive TB test (to be completed by physician):

Students who test positive for TB must provide annual documentation from their Health Care Provider indicating there are no signs or symptoms of active Tuberculosis. The assessment may or may not include a new chest x-ray.

Date of Positive TB Test: _______________________ Treatment: _____ Yes _____ No

Does this student show signs of active TB: _____ Yes _____ No

Does this student require an updated chest x-ray: _____ Yes _____ No

Attach original or new chest x-ray report.

PART D: Clinic Stamp and Signature of Physician or Nurse

Physician or Nurse Name (please print): ___________________________________

Clinic Address: ____

Clinic Telephone #: _______________________

Signature: _______________________________ Date: _________________

Please place clinic stamp in box below.

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