CATHOLIC HEALTH

--- *Provider Annual Health Assessment* & Tuberculosis Screening---

Provider Name: _____

ANNUAL TUBERCULOSIS SCREENING: Please fill in most recent results for annual Tuberculosis screening test or reasons for exclusion (if applicable) in the tables below. Individuals with negative screening tests must repeat tuberculosis screening test annually.

NOTE: Pregnancy and/or breastfeeding does not exclude providers from PPD skin testing. History of BCG vaccination is not a contraindication to receiving the PPD skin test.

TUBERCULOSIS SCREENING TEST		
Test Name (Check one of the below options)	**Test Date** (mm/dd/yy)	**Test Result**
□ Tuberculin Skin Test (PPD)		Induration: _____ mm □ Negative Date Read:_____ Individuals with **new Positive PPD** □ Positive ***(Answer symptoms questions below)** Chest X-Ray Date: Result:
□ QuantiFERON-Tb Gold (if obtained)		□ Negative □ Positive ***(Answer symptoms question below)**
□ T-Spot (if obtained)		□ Negative □ Positive ***(Answer symptoms question below)**
***SYMPTOMS** Have you had any of the following symptoms persisting for ≥ 3 weeks: cough, loss of appetite, unexplained weight loss, night sweats, bloody sputum, new hoarseness, or unexplained fever? □ Yes □ No		

EXCLUSION FROM ANNUAL TUBERCULOSIS SCREENING TEST		
□ Excluded from annual Tuberculosis Testing	N/A	Reason for Exclusion: (Please check one and answer symptoms question below) □ Significant prior adverse reaction to testing □ Known prior positive test with negative workup for active Tuberculosis or previous completion of treatment for Tuberculosis
*SYMPTOMS Have you had any of the following symptoms persisting for ≥ 3 weeks: cough, loss of appetite, unexplained weight loss, night sweats, bloody sputum, new hoarseness, or unexplained fever? □ Yes □ No		

ANNUAL HEALTH ASSESSMENT STATEMENT:

I have determined, to the best of my knowledge, that the above-named practitioner is free from any health impairment which is of potential risk to patients or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol, or other drugs or substances which may alter the individuals behavior.

_____ _____

[Signature of your Practitioner] *[Date]*

(Note: Applicants Cannot Sign for Themselves)

_____

[Typed or Printed Name of your Practitioner]

Please Return to System Verification Office:

- **Fax: 716-828-2243**
- **Email: CH-SVO-MDSTAFF@chsbuffalo.org**

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