Print Form Reset Form

STATE OF CALIFORNIA — DEPARTMENT OF CORRECTIONS AND REHABILITATION

EMPLOYEE TUBERCULIN SKIN TEST (TST) AND EVALUATION

CDC 7336 (Rev. 10/02)

CONFIDENTIAL EMPLOYEE MEDICAL INFORMATION

INSTRUCTIONS: Tuberculosis (TB) screening must be performed by a licensed health care provider whose legally authorized scope of practice allows him/her to conduct medical examinations and/or the Mantoux TB Skin Test (TST) in accordance with the recommendations of the Centers for Disease Control and Prevention to determine if a person has TB infection or disease.

EMPLOYEE (Complete the following section type or print clearly)

1	EMPLOYEE INFORMATION	
PRINT OR TYPE EMPLOYEE'S FULL NAME (AS IT APPEARS ON STATE PAYCHECK) FIRST MI LAST		GENDER ☐ MALE ☐ FEMAILE
BIRTHDATE	LAST 6 DIGITS OF SOCIAL SECURITY NUMBER	NEW EMPLOYEE/CADET ☐ YES ☐ NO
INSTITUTION OR DIVISION	UNIT OR BRANCH	DEPARTMENT (IF NOT CDCR)
EMPLOYEE SIGNATURE		DATE

HEALTH CARE PROVIDER (Complete Sections 2 6 as required refer to instructions)

2	PRIOR TST/TB HISTORY (AS DOCUMENTED IN THE EMPLOYEE HEALTH CARE RECORD) NOTE: PRIVATE PROVIDERS ATTACH DOCUMENTATION OF PRIOR HISTORY	
PRIOR SIGNIFICANT TB SKIN TEST/INFECTION ☐ YES ☐ NO	IF YES, DATE:_____ INDURATION SIZE: _____MM	PRIOR TB DISEASE ☐ YES ☐ NO

NOTICE: HIV AND OTHER MEDICAL CONDITIONS MAY CAUSE A TST TO BE NEGATIVE WHEN TB INFECTION IS PRESENT

3	TST ADMINISTRATION (5 TU/0.1 milliliter)				
(CHECK ONE) LOT NUMBER ☐ TUBERSOL ☐ APILSOL _____	EXPIRATION DATE	TST ADMINISTERED BY (PRINT NAME)	SIGNATURE	DATE	
INJECTION SITE ☐ LFA* ☐ RFA **	INJECTION DATE	INTERPRETATION	TST RESULT (M INDURATION)	DATE TST READ/OR OF SIGN & SYMPTOM EVALUATION	
4	EVALUATION FOR SIGNS AND SYMPTOMS (MUST BE COMPLETED FOR ALL INDIVIDUALS)				
☐ NO SYMPTOMS	SYMPTOMS (CHECK ALL THAT APPLY) ☐ WEIGHT LOSS (UNEXPLAINED) ☐ UNEXPLAINED FATIGUE ☐ PERSISTENT (>2 WKS) COUGH ☐ UNEXPLAINED FEVER ☐ UNEXPLAINED NIGHT SWEATS				
5	CHEST XRAY				
☐ CHEST XRAY NEEDED ☐ CHEST XRAY REPORT ON FILE (COPY REQURIED)	CHEST XRAY RESULT ☐ NORMAL ☐ ABNORMAL	CONSISTENT W/TB ☐ YES ☐ NO			
6	COMMENTS ☐ EMPLOYEE REFERRED FOR FOLLOWUP MEDICAL EVALUATION ☐ EMPLOYEE PROVIDED WRITTEN NOTIFICATION OF TST RESULTS ☐ NO SHOWEMPLOYEE NOTIFIED				
☐ EMPLOYEE IS FREE OF INFECTIOUS TUBERCULOSIS					
EVALUATOR NAME	EVALUATOR SIGNATURE			DATE	

*LFA: LEFT FOREARM
**RFA: RIGHT FOREARM

NOTICE TO PRIVATE PHYSICIANS ON NEXT PAGE
PLEASE READ PRIOR TO TESTING