TB Testing

Name: ________________________________ Date of Birth__________________________

KSU ID #______________________________ Phone Number ________________________

KSU E-mail ___________________________ Current Course # _______________________

*QuantiFERON Gold date ____/_____/____ Results: __________ (copy of lab report required)

OR

*T-Spot date ____/_____/____ Results: __________ (copy of lab report required)

OR

*Chest x-ray date ____/_____/____ (copy of x-ray report required)
(*only if previous PPD or QuantiFERON reading is positive*)

* Treatment for latent TB, please include medication dose, frequency and duration:

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Health Care Provider's Signature:____________________________ Date:___/_____/____

Health Care Provider's Name: (Print) ____

Address:____

Telephone Number: ____