Tuberculosis Screening Affidavit

Kaweah Delta HEALTH CARE DISTRICT

It is the policy of Kaweah Delta Health Care District to require annual skin testing for all healthcare workers, regardless of employment status. Please complete the section below and return this form to the Medical Staff Services Office.

Print name: _____

Use this section to record your PPD test.

Date placed/Time: _____ ( ) LFA ( ) RFA
Lot # _____ Exp. Date: _____

Provided by: _____: _____
Signature

Results: ☐ Negative _____mm induration
☐ Positive _____mm induration
Date read/Time: _____
HCP: _____

ONLY USE THE SECTION BELOW

IF YOU HAVE A HISTORY OF **POSITIVE** PPD

Do you have symptoms of active TB Disease? ☐ Yes ☐ No

Date of last chest X-ray: _____
Result: _____
(Must attach a copy of the chest X-ray report – A new chest x-ray is only required upon the development of TB symptoms)

I certify that I have read and understand the Kaweah Delta Health Care Districts Tuberculosis Screening Policy & Procedure and to the best of my knowledge, the above results & information are correct.

Signature: _____**Date:** _____

Please fax completed forms to Medical Staff:
(559) 735-3058