STATE OF CALIFORNIA

EMPLOYEE TUBERCULIN SKIN TEST (TST) AND EVALUATION

CDC 7336 (Rev. 10/02)

DEPARTMENT OF CORRECTIONS

DISTRIBUTION:
WHITE : HCSD PUBLIC HEALTH SECTION
YELLOW : EMPLOYEE MEDICAL FILE
PINK : EMPLOYEE

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 ☐ FEMALE
BIRTHDATE	LAST 6 DIGITS OF SOCIAL SECURITY NUMBER	NEW EMPLOYEE/CADET ☐ YES ☐ NO
INSTITUTION OR DIVISION	UNIT OR BRANCH	DEPARTMENT (IF NOT CDC)
EMPLOYEE SIGNATURE		DATE

HEALTH CARE PROVIDER (Complete Sections 2-6 as required - refer to instructions on reverse side of form)

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 (IF YES, DATE) ☐ 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 ☐ SIGNIFICANT ☐ INSIGNIFICANT	TST RESULT (MM INDURATION)	DATE TST READ/ OR OF SIGN & SYMPTOM EVAL.

4 EVALUATION FOR SIGNS AND SYMPTOMS (MUST BE COMPLETED FOR ALL INDIVIDUALS)

☐ NO SYMPTOMS

SYMPTOMS (CHECK ALL THAT APPLY)
☐ PERSISTENT (>2 WKS) COUGH
☐ WEIGHT LOSS (UNEXPLAINED)
☐ UNEXPLAINED FEVER
☐ UNEXPLAINED FATIGUE
☐ UNEXPLAINED NIGHT SWEATS

5 CHEST X-RAY

☐ CHEST X-RAY NEEDED
☐ CHEST X-RAY REPORT ON FILE (COPY REQUIRED)

CHEST X-RAY RESULT
☐ NORMAL
☐ ABNORMAL
CONSISTENT W/TB ☐ YES ☐ NO

6 COMMENTS:

☐ EMPLOYEE REFERRED FOR FOLLOW-UP MEDICAL EVALUATION
☐ NO SHOW-EMPLOYEE NOTIFIED
☐ EMPLOYEE PROVIDED WRITTEN NOTIFICATION OF TST RESULTS

☐ **Employee is Free of Infectious Tuberculosis**

EVALUATOR NAME	EVALUATOR SIGNATURE	DATE

* LFA : Left Forearm
** RFA: Right Forearm

NOTICE TO PRIVATE PHYSICIANS ON REVERSE SIDE
PLEASE READ PRIOR TO TESTING