EMPLOYEE TUBERCULOSIS SCREENING FORM
2018

Please have this form completed properly then submit it to the worksite whose payroll lists your name by _____. This is necessary to comply with Section 25103, Title 10, Guam Code Annotated, which requires you to be screened for tuberculosis as a condition of employment or doing volunteer work, and annually thereafter. Failure to comply can and will be grounds for placing you on leave without pay until the required documentation is submitted.

Please note the following:

- The items on this form require that they be completed within certain time Period to be valid. Different items have different time periods.
- Applicants for employment must first submit of this form to the Personnel Services Division before beginning work.

I the undersigned do hereby give my full consent to the University of Guam Student Health Service to perform the test for the maintenance of my good health and to satisfy my employment requirement.

Signature: **Date:**

Name of Employee/Volunteer: _____ D. O. B. _____

SS# OR UOG#: _____ Work Location/Dept.: _____

DIRECTIONS

Directions: *Completely read the following items and do what is indicated by them; many require you to Continue to another item. Items shown in small print must be completed by a Physician, Physician's Assistant (PA), Nurse Practitioner (NP), or Nurse; refer to each item for specifics.*

1. If you are not a positive TB test reactor, start wit Item 2.
   If you are a positive TB test reactor but have not received treatment for TB, start with Item 6.
   If you are under or have received completed treatment for TB: do Item 9.

2. Obtain a PPD skin test and have the following information complete. Then do Item 3.
   (The results must be less than a year old on the date at the top to be valid. You may attach other medical documentation to this form with shows the date of administration and reading of a PPD instead of having this items completed. However, you are still responsible for having all other items which apply to your situation properly completed on this form.).

Date administered: _____ Date read: _____ Results: _____ mm

_____	_____	_____
Name of Physician, PA/ Nurse (print)	Date	Signature of Physician, PA/ Nurse

3. a) If a result from Item 2 is 0-9mm or negative, disregard the following items.
   b) If the result from Item 2 is 10mm or greater: do Item 4

4. Obtain a chest X-ray and: a) Have the following completed by only a Physician, PA, or NP; and b) Attach a radiology report concerning the X-ray from a licensed radiologist. Then do Item 5. (If this is done in compliance with Item 3: the X-ray must have been conducted no sooner than in six months prior to the PPD required by item 2 to be considered valid. If this is done in compliance with Item 6: the X-ray must have been conducted no sooner than six months prior to the date shown at the top of the other side to be considered valid). If you are pregnant, do Item 7 if you are less than 20 weeks pregnant (in this case Item 7 may be completed only by a Physician); otherwise, do this item, then Item 5 (tell the clinic you need an abdominally shielded X-ray because of your pregnancy).

   1.) Are X-ray results suggestive of TB? [ ] yes [ ] no

   2.) Date the X-ray was administered: _____

   3.) Is the patent currently on INH prevention therapy? [ ] yes [ ] no

continued. . .

If not, please state reason:

[ ] Patient refused INH preventive therapy offered

[ ] Patient over 35 years of age with no risk factor

[ ] Patient referred to DPH&SS for possible INH preventive therapy

[ ] Patient referred to DPH&SS for possible active TB

Other: _____

_____ _____ _____

Name of Physician, PA/NP/Nurse (print) **DATE** Signature of Physician/PA/NP/Nurse

5. a.) If the answer to Item 4.1 is "no", disregard the following items.
   b.) If the answer to Item 4.1 is "yes", do Item 9

6. a.) If the last time you had a chest X-ray was during or before 2009: do Item 4.
   b.) If you had a chest X-ray after 2009 and had submitted its radiology report with Item 4 properly completed to the University of Guam for a previous TB screening: do Item 7. Otherwise, do Item 4.

7.) Have the following item completed by only a Physician, Physician's Assistant (PA), or Nurse Practitioner (NP). Then do Item 8. (This item must have been completed no sooner than one year prior to the date shown at the top of the other side to be valid.)

Does the person name on page 1 have any of the following?

A.)	Chronic cough: (Two (2) weeks duration or longer)	[ ] YES [ ] NO
B.)	Chronic cough with sputum	[ ] YES [ ] NO If yes, color of sputum _____
C.)	Coughing Blood	[ ] YES [ ] NO
D.)	Persistent night sweats	[ ] YES [ ] NO
E.)	Involuntary Weight Loss	[ ] YES [ ] NO
F.)	Unexplained fevers	[ ] YES [ ] NO

_____ _____ _____

Name of Physician/PA/NP (print) **DATE** Signature of Physician/PA/NP

8. a.) If all of the symptoms A-F in Item 7 were answered "no", disregard the remaining Items.
   b.) If any of the symptoms A-F were answered "yes" in Item 7: do Item 4. (However, in this case the X-ray required by Item 4 will be considered valid only if it has been conducted no more than one month prior to, or anytime after, when Item 7 has been signed).

9. Have the TB Control Section of the Department of Public Health & Social Services in Mangilao complete the following: clearances from anywhere else will not be accepted (Call 735-7145/7157 for an appointment. When doing so, ask what documents you should bring to get cleared).You may return to work or resume your job application process on the date indicated on the left below.

May start/return to work on: _____ DPH&SS stamp:_____

DPH&SS Staff Signature: _____Date: _____

LATENT TUBERCULOSIS INFECTION (LTBI) QUESTIONNAIRE

PLEASE SUBMIT FOR CLEARANCE REQUEST FOR PATIENTS HAVING POSITIVE TB SKIN TEST

NAME		**DOB** ____/____/____	
ADDRESS			
ETHNICITY		**PHONE NUMBERS: (HOME/WORK/MOBILE)**	

PPD SKIN TEST	Date given:	Date read:	Results: _____mm
Chest X-Ray (Copy of report **MUST** Be Attached)	Date of CXR exam:	☐ Normal ☐ Abnormal	Comments: _____ _____
LTBI Treatment	Date treatment started:	Date completed:	☐ No h/o treatment
	Adverse reactions to LTBI therapy? ☐ YES ☐ NO	Patient declined therapy? ☐ YES ☐ NO	

Have you been exposed to active TB? ☐ YES ☐ NO

SYMPTOMS	YES	NO
Cough		
Fever		
Weight loss		
Night sweats		
Fatigue		
Chest pain		
Shortness of breath		
Hoarseness		

If response is "yes" to any of the symptoms, patient will need a repeat 2 view CXR before referral to Public Health for clearance.

Please include findings from repeat CXR (Copy of report **MUST** be attached)**:**

☐ Normal

☐ Abnormal

Patient is cleared for work/school	☐ Yes	☐ No
Patient is referred to the Department of Public Health Communicable Disease Clinic for possible active tuberculosis (**All required documents MUST accompany referral**).	☐ Yes	☐ No

Physician Signature/Stamp **Name of Physician/Clinic** **Date (Valid 90 days)**

DEPARTMENT OF PUBLIC HEALTH & SOCIAL SERVICES
BUREAU OF COMMUNICABLE DISEASE CONTROL
TUBERCULOSIS/HANSEN'S DISEASE CONTROL PROGRAM
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671-735-7157/7131/7120/7145

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