FTTA TB Screening Form

To be completed by medical practitioner administering/reading the TB skin test or documenting previous treatment.
The clinic, doctor's office or the applicant should either fax this form to (714) 991-8537 or email it to **medicalreview@ftta.org**

Important: Document must be completed strictly following all the instructions or results will not be accepted.
**Application will not be processed until TB Test Results are received.*

Name: _____ Gender: _____ Date of Birth: _____
(The name on this form must be the same as the legal name on the FTTA application.) (month/day/year)

Please complete ***one*** of the following four options and submit the required documentation:

1. **Purified Protein Derivative (PPD) Skin Test –** *Must be read between 48-72 hours from date/time placed.* Documentation, in English, of a *negative PPD* performed within **6 months** of your Training start date. Please use month/day/year format for dates.

   Date of PPD Placement _____ Time _____ Placed By: _____

   Date of PPD Reading _____ Time _____ Read By: _____

   Result (circle one): Negative or Positive Diameter of Reading _____ mm of induration (*required)

2. **Quantiferon or T-Spot Blood Test**
   Lab report (including numerical values), in English, of a *negative Quantiferon or T-Spot*. TB blood test must have been performed within **6 months** of your Training start date.

3. **Chest X-Ray**
   Report of a chest x-ray, in English, signed by a radiologist, with no evidence of active tuberculosis performed within one year of start of Training. Include a copy of the chest x-ray in electronic format. If the chest x-ray is unavailable in electronic format, you may take a good picture of the film copy of the chest x-ray and submit it via email to: medicalreview@ftta.org. Chest x-ray must be completed within **one year** of Training start date.

4. **Course of Treatment or Prophylactic Treatment of Tuberculosis**
   Documentation, in English, of a completed course of treatment or prophylactic treatment of tuberculosis.

   Was the treatment (circle one): curative or prophylactic
   If curative, date of negative AFB smear _____
   Medications and Doses _____
   _____
   Date Treatment Began: _____
   Date Treatment Completed: _____

Printed Name: _____ Professional Title _____ Date _____
(month/day/year)

Signature: _____

Clinic/Physician's Office Stamp

REQUIRED

Country the test was performed in:

_____