



TB Skin Test Record

Printed Name

was administered the following:

PPD Test_____	Date_____	Site_____	Results_____
PPD Test_____	Date_____	Site_____	Results_____
Chest Xray_____	Date_____	Site_____	Results_____

Signature, written name, and Title of Person Administering Test

Signature, written name, and Title of Person Reading Results

Location of Test Administration (name of Doctor’s office, clinic, Health Dept. etc.)

***Proof of PPD TB Skin test or chest x-ray must be dated within the last 12 months. The 2 step PPD TB test requires at least 2 weeks. Please plan ahead so that you have the results prior to the first day of class. This is a REQUIREMENT for the program and to train/work in the HealthCare Field.**

