



INITIAL and ANNUAL TUBERCULOSIS SCREENING QUESTIONNAIRE
 (This Form is to be used for those with a previously positive TB Skin Test, i.e., positive PPD.)

First Name: _____

Middle Initial: _____

Last Name: _____

Positive TB Skin Test (PPD Date): _____

Date of Last Chest X-Ray: _____

Please indicate if you have had any of the following conditions for three to four weeks or longer:

SIGN OR SYMPTOM	YES	NO
Chronic Cough (greater than 3 weeks)		
Production of Sputum (productive cough)		
Blood Streaked Sputum		
Unexplained Weight Loss		
Unexplained Fever		
Weakness/Fatigue/Tiredness		
Loss of Appetite		
Night Sweats		
Shortness of Breath		
Chest Pain with Coughing		
Rapid Heart Rate (Tachycardia)		

The information provided above is true and accurate. I understand that if I experience any of the above signs of illness, I must notify Synergy Medical Staffing, Inc. and my primary healthcare provider immediately. Further, I acknowledge that eligibility for assignments is dependent upon a physician's or primary care provider's verification that I am free of infectious disease and do not have any condition which would interfere with the performance of my assignment duties.

Applicant/Healthcare Associate Signature: _____

Date: _____

Physician Signature: _____

Date: _____

Authorized Healthcare Provider Signature: _____

Date: _____