

TB (TUBERCULOSIS) SKIN TEST CERTIFICATE

PATIENT FULL NAME: _____

PATIENT ADDRESS/CITY/STATE/ZIP: _____

PATIENT DATE OF BIRTH: _____ PHONE: (____) _____

TESTING LOCATON (BUSINESS): _____

TESTING LOCATION ADDRESS: _____

TESTING LOCATION PHONE: (____) _____ FAX:(____) _____

A Trained Healthcare worker should read the TST 48 to 72 hours after the intradermal injection.

Nurse completes section below

PLACEMENT							READING		
PPD	Mfg Name	Lot#	Exp Date	Placement Date	Site	Nurse	Reaction	Read Date	Nurse
1							mm		
2							mm		

- In order for this document to be valid/acceptable, all sections of this form must be completed.