

NAME OF STUDENT _____

BIRTH DATE _____ SSN _____

EDUCATIONAL INSTITUTION _____

I certify that a 5 TU Mantoux PPD skin test was applied on _____ and was read on _____
(mo/day/yr) by me or a licensed nurse under my supervision. The reading was _____ mm induration.
(mo/day/yr)

Name: _____ M.D. D.O. RN/RNP/LPN PHN School Nurse
First M.I. Last

Address: _____
Street Address or P.O. Box

City State Zip Signature _____

I certify that an antero-posterior erect chest radiograph was made on _____ and that it revealed
(mo/day/yr)

no evidence of tuberculosis, with the exception of calcified lymph nodes and/or nodules.

abnormalities consistent with scarring due to inactive tuberculosis.

abnormalities consistent with active tuberculosis.

If certifier is the same as above, he may check here and omit name and address below.

Name: _____ M.D. D.O.
First M.I. Last

Address: _____ Medical Specialty: Radiology Pulmonology
Street Address or P.O. Box

City State Zip Signature _____

Treatment Recommended: Yes No