



TUBERCULOSIS (TB) SURVEILLANCE FORM

Employee Name: _____
Print Name

Date Completed: _____

Date of PPD positive conversion: _____

CXR completed Yes/No Date _____

Did you receive BCG? Yes/No When _____ Where _____

***ANSWER YES FOR ANY UNEXPLAINED SYMPTOM!**

Do you have a persistent cough? Yes/No

Are you coughing up blood? Yes/No

Have you had a fever lasting more than 3 days? Yes/No

Have you had unexplained weight loss? Yes/No

Do you have a chronic fever? Yes/No

Do you suffer from chest pain? Yes/No

If you answered yes to any of the above questions, please explain below:

If you answer yes to any of the questions above, you are required to have a doctor's clearance prior to working.

Employee Signature: _____ Date: _____

CTS Signature: _____ Date: _____

Please SIGN and RETURN this form to your Local CTS Office:

Washington / Virginia Regional Office – Compliance Fax: 703-354-0852

Baltimore Regional Office – Compliance Fax: 410-321-0079