

# REQUEST FOR TUBERCULOSIS STATEMENT

**To:** Physician/Health Department

**Date:** \_\_\_\_\_

**From:** \_\_\_\_\_

*Local Department of Social Services*

*Address*

*Agency Representative*

Standards for local agency approved providers of care for clients require that the individual identified below obtain a statement that he/she is believed to be free from tuberculosis in a communicable form.

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Type of Care Provided:** \_\_\_\_\_

*This section is to be completed by a physician for provider named above.*

**Date of Test:** \_\_\_\_\_

**Type of Test:** \_\_\_\_\_

**Is this person believed to be free from tuberculosis in a communicable form?**

**Yes**\_\_\_\_ **No**\_\_\_\_

**Physician's**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Name of Physician:** \_\_\_\_\_

*(Print or Type)*

**Address:** \_\_\_\_\_

*Telephone*