# Mandatory TB Skin Test

| Full Name: | Address: |
|---|---|
| Date of Birth: | |

*STOP:* *THIS TEST MAY NOT BE PLACED OR READ BY A MEDICAL ASSISTANT, LPN, CNA OR ANY OTHER PROFESSIONAL UNDER A REGISTERED NURSE.*

PLACED by (Print name): _____ (check one) RN___MD/DO____CRNP____

PLACED by (Signature): _____

DATE PLACED: _____

*STOP:* *THIS TEST MAY NOT BE PLACED OR READ BY A MEDICAL ASSISTANT, LPN, CNA OR ANY OTHER PROFESSIONAL UNDER A REGISTERED NURSE.*

READ by (Print name): _____ (check one) RN___MD/DO____CRNP____

READ by (Signature): _____

DATE READ: _____ *RESULT: _____

**IF POSITIVE PPD, last chest x-ray: Date:* _____ *Result:* _____

*A copy of x-ray report must accompany this form* *(an x-ray does not replace a standard skin test unless false positives are part of an individual's history and must accompany a letter from PCP attesting this information)*

Please mail or fax to:

**2nd Home Adult Day Care**
1614 Old York Road
Abington, PA 19001
Ph: 215-366-5955
Fax: 855-248-5959