State Center Community College District

Certificate of Completion

Tuberculosis Risk Assessment and/or Examination

To satisfy job-related requirements in the California Education Code, Sections 49406 and 87408.6 and the California Health and Safety Code, Sections 1597.055, 121525, 121545 and 121555.

_____ _____ _____ _____
LAST Name *First Name* *Date of Birth* *Employee ID#*

_____ _____
Address *Phone*

❑ Academic ❑ Classified ❑ Provisional/Limited Term ❑ Student Worker ❑ Exempt ❑ Volunteer

SECTION A: TB Risk Assessment Results. To be completed by District Health Services.

❑ No risk factors for tuberculosis. *Section B is NOT required.*

❑ Current Employee w/Past Positive that was cleared with CXR in past. *Section B is NOT required.*

❑ Results of TST or IGRA completed on _____ are negative. This individual has been determined to be free of infectious TB. *Section B is NOT required.*

❑ Referred to health care provider on _____ for TB Assessment/Exam due to:

___ History of Past Positive ___ Other *(specify)*: _____

Completion of Section B below is required.

_____ _____
Signature of District Nurse completing the risk assessment *Date*

SECTION B: To be completed by a healthcare provider.

I have evaluated/examined the above named patient for tuberculosis risk factors and/or disease and have determined the patient to be free of infectious tuberculosis.

CXR within past 6 months is required.

Date of most recent CXR: _____

Results of CXR:

❑ Negative CXR - no indication of active TB

❑ Other *(specify)*: _____

_____

_____

Provider Name: _____

Provider Signature: _____

Date: _____

Provider Stamp:

SECTION C: To be completed by District Health Services. *Health Services Stamp:*

❑ Clearance complete - Requires reassessment in 4 years

❑ Clearance complete - No reassessments needed.

❑ Partial clearance - Requires CXR within 60 days after termination of pregnancy

_____ _____
Signature of District Nurse completing the risk assessment *Date*