CUA

THE CATHOLIC UNIVERSITY OF AMERICA

School of Nursing

Washington, DC 20064

202-319-5400

FAX 202-319-6485

Annual – Tuberculin Test (PPD)

PPD date: _____

Results (positive or negative): _____

Student Name: _____

Student Signature: _____

Primary Care Provider Name: _____ (PRINT)

Primary Care Signature: _____ (SIGNATURE)

Primary Care Provider Address: _____

_____

Telephone Number: _____

Nursing Students Who Have Tested POSITIVE to PPD Skin Test

If you have a positive PPD, you must have a health care provider certify that you have had a negative Chest X-ray within the past 5 years.

Date of Chest X-ray: _____

Chest X-ray results: _____

Student Name: _____

Student Signature: _____

Primary Care Provider Name: _____ (PRINT)

Primary Care Provider Signature: _____ (SIGNATURE)

Primary Care Provider Address: _____

_____

Telephone Number: _____

*****MUST BE SUBMITTED ANNUALLY***** *****DO NOT SUBMIT TO SON, SUBMIT TO CERTIFIEDBACKGROUND.COM**

June 2012