

Certificate of Tuberculosis (TB) Screening

Georgia Institute of Technology • Language Institute • Atlanta, GA 30332-0374 USA

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Student's Name: _____
FAMILY NAME FIRST NAME MIDDLE NAME

Date of Birth: _____ / _____ / _____ GT ID # _____
Month / Day / Year

Local Address: _____
Street City State/Country Mail Code

Home Country Information: _____
City State/Country

One of the following must be completed within 1 year of starting classes.

Tuberculin (Mantoux) Skin Test

- The skin test must be performed by a medical provider inside the United States.
- Results of a skin test **performed outside** the United States **cannot** be accepted.

Mantoux Only: Inject 0.1 ml of purified protein derivative (PPD) tuberculin containing 5 tuberculin units (TU) intradermally into the volar(inner)surface of the forearm.

Date Placed: month _____ day _____ year _____

Date Read: month _____ day _____ year _____ (must be within 48-72 hours)

Result: _____ mm
(Record actual mm of induration, transverse diameter. If no induration, record as "0 mm")

Interpretation: Positive ____* Negative ____ (based on mm of induration as well as risk factors)

(*If positive, a chest x-ray is required)

Chest X-Ray

Date of chest x-ray: month _____ day _____ year _____

Result: Normal _____
Abnormal _____ *

(* a copy of the x-ray report, written in English, and signed by the physician must be included)

This section MUST BE COMPLETED by the physician or health care provider

Medical Provider Name (Please type/print) _____
Medical Provider Signature _____ Date _____
Address _____ _____
Telephone Number _____ Fax Number _____