

Tuberculosis Screening Questionnaire

This questionnaire must be completed annually by employees with a history of a positive TB skin test (PPD). Please provide all the information requested below and return this questionnaire to your Staffing Coordinator.

Name: _____

Position: _____

Date of Positive PPD: _____

Date of Negative CXR : _____

Please indicate if you have been experiencing any of the following symptoms for three weeks or longer:

- | | | |
|---|------------------------------|-----------------------------|
| 1. Productive Cough | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. Blood-streaked Sputum | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3. Fatigue/Tiredness | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 4. Unexplained Weight Loss | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 5. Loss of Appetite | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 6. Night Sweats | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 7. Fever/Chills | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 8. Shortness of Breath | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 9. Generalized Swollen Glands | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 10. Any other unusual symptoms (if so, please explain)? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

I acknowledge and understand that Alliant Staffing (the "Company" and its clients require the information provided above to make decisions regarding my employment with the Company and assignments to its clients. I authorize the Company to share this questionnaire with any Alliant client to which I am assigned or seek to be assigned.

Employee Signature:

Date:

Signature of Examining Practitioner:

Date:

Physician/Practitioner Name: _____

Address: _____

Telephone: _____