CENTRAL COAST Healthcare

high-tech care, hometown touch

CERTIFICATE OF TUBERCULOSIS TESTING

Patient/Employee Name: RICHARD JOHNSON

SS#: 553-88-2353 DOB: 4/5/52

I consent to receiving the Tuberculosis skin test:

Patient Signature: _____ Date: 3/11/15

Please answer the following:

- I have had a positive PPD skin test in the past or have received the BCG or similar vaccination. Yes ____ No X
- If yes, date of last Chest X-ray: _____ Report attached: Yes ___ No ___

CURRENT CHEST X-RAY REQUIRED: YES NO

Date Performed: _____ Results _____

PPD Skin Test Date Given: ~~3.10.15~~ 3.11.15 LF Time: 0847 Site: RF (LF)

Lot # 717240 . Exp. Date: 2/16 Brand: Aplisol

Given By: L Frederick

Date Read: 3.13.15 Time: 4:00pm Reaction: (NEG) POS

mm of induration: 0 New Converter: YES NO

Morbidity report filed on: _____ By: _____

The above patient has been evaluated to detect evidence of active Tuberculosis. Following appropriate skin testing or x-ray evaluation, I find no evidence of active Tuberculosis at this time.

_____ 3.13.15

Medical Provider Signature Date