U.S. DEPARTMENT OF COMMERCE
NATIONAL OCEANOGRAPHIC AND ATMOSPHERIC ADMINISTRATION

TUBERCULOSIS SCREENING DOCUMENT

This form must be used to document the annual tuberculosis screening required by NOAA Policy 1008 of all persons seeking medical clearance by NOAA Health Services to sail on a NOAA ship.

NAME	YEAR OF BIRTH	DATE

SECTION 1: To be completed by the healthcare professional performing the tuberculosis testing.

TST TEST RESULTS			**QUANTIFERON GOLD OR T-SPOT RESULT** (COPY OF RESULTS MUST BE INCLUDED)		
DATE GIVEN	DATE READ		DATE TEST OBTAINED	TEST OBTAINED ☐ QFT-G ☐ T-SPOT	
RESULT _____ (mm induration)	INTERPRETATION ☐ POSITIVE ☐ NEGATIVE		TEST RESULT ☐ NEGATIVE ☐ POSITIVE ☐ INDETERMINATE/BORDERLINE		
PROVIDER NAME (PRINT)	PROVIDER SIGNATURE	DATE	PROVIDER NAME (PRINT	PROVIDER SIGNATURE	DATE

SECTION 2: To be completed **ONLY** if you had positive results in Section 1 or have a history of a positive TST test or positive/indeterminate Quantiferon Gold or T-Spot blood test.

Please consider the following questions: (mark the appropriate answer)

1. Have you ever had a positive TB skin Test? ☐ NO ☐ YES If yes, when _____
2. Date of your last chest x-ray (if applicable) _____
3. Date of BGG Vaccine (if applicable) _____
4. Date you completed your prescribed medications to treat your positive TB Test (if applicable) _____
5. Have you ever lived with or been in close contact with anyone who had TB disease? ☐ NO ☐ YES
6. Have you ever had a positive HIV test? ☐ NO ☐ YES
7. Have you ever used illegal intravenous drugs? ☐ NO ☐ YES
8. Are you currently taking steroids, chemotherapy, or cancer treating drugs? ☐ NO ☐ YES
9. Have you ever been incarcerated? ☐ NO ☐ YES
10. Have you ever been homeless? ☐ NO ☐ YES
11. Do you currently have any of the following symptoms? (check if YES)

    ☐ Fever ☐ Weight Loss ☐ Night Sweats ☐ Chronic Cough ☐ Chronic Fatigue ☐ Coughing up blood

12. Consider the following list of high burden countries that account for 80% of new TB cases each year:

Afghanistan	*DR Congo*	*Mozambique*	*Brazil*	*Kenya*	*Philippines*	*UR Tanzania*
Myanmar	*South Africa*	*Zimbabwe*	*China*	*Vietnam*	*Bangladesh*	*Ethiopia*
Indonesia	*Pakistan*	*Uganda*	*India*	*Nigeria*	*Thailand*	*Cambodia*
						Russian Federation

- Were you born in one of the countries listed above? ☐ NO ☐ YES
- Have you ever stayed/lived in one of these countries for one month or longer? ☐ NO ☐ YES
- Have you ever lived or been in close contact with someone who stayed/lived in one of these countries for one month or longer? ☐ NO ☐ YES

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I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service. I understand that falsification of information on Government forms is punishable by fine and/or imprisonment.

SIGNATURE	SIGNATURE DATE

NOAA policy requires that all persons with a recent or remote positive test for exposure to the tuberculosis bacteria must obtain an annual physical examination by a licensed medical provider (physician, nurse practitioner, or physician assistant) to determine if latent TB infection or active disease is present, and if persons with latent infection are at high risk for developing active disease. This annual examination must include interpretation of a chest x-ray less than 5 years old. Center for Disease Control and Prevention (CDC) Guidelines and NOAA Health Services policy require persons with latent infections who are at high risk of developing active disease to initiate prophylactic treatment before obtaining medical clearance from NOAA Health Services to sail on a NOAA ship.

I have examined this patient following the NOAA Medical Policy and determined this patient has:

☐ **Latent TB** infection with **low risk** of developing active disease.

☐ **Latent TB** infection with **high risk** of developing active disease.

Prophylactic Medication/s Prescribed: _____

Date Prophylactic Medication began _____ Date Prophylactic Medication will be completed _____

☐ **Active Tuberculosis.**

PROVIDER CONTACT INFORMATION (ADDRESS)	PROVIDER CONTACT TELEPHONE NUMBER
PROVIDER TITLE	DATE OF EXAMINATION
PROVIDER PRINTED NAME	PROVIDER SIGNATURE

SUPERSEDES NOAA Form 57-10-02 (4-12)

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