

FCC Provider's Name: _____

Date _____

This is to state that _____ is free from Tuberculosis (TB).
(patient's name)

Test Date: _____

Date Test Read: _____

Test Results Positive Negative


If test positive, please explain _____

Date

Test Administrator's Signature

Telephone

Address

 This form is to be used when only a TB test is required or when the physician does not do TB testing.
This form must accompany the physician statement.

Form #4119:revised 2005

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