Physician Certification Form for TB Test

Office of Partnerships, Professional Experiences, and Outreach
Shippen Hall 354: **Location**
717-477-1487: **Phone**
717-477-4012: **Fax**

Personal and Physician Information			
Student's Name:		Physicians Name:	
Birthdate:		Name of Practice:	
Phone number:		Phone number:	
Student ID:		Practice Address:	

Testing Information	
NOTE: Tuberculosis Test Results must be read in millimeters and interpretation must follow the CDC guidelines.	
Date Applied:	
Date Read:	
Result:	
Interpretation	Positive: _____ Negative: _____

I certify that to the best of my knowledge the information above is full, complete, and true.

_____ _____

Physician Signature **Date**