SHIPPENSBURG UNIVERSITY
College of Education and Human Services

Physician Certification Form for TB Test

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

Student's name_____

Student ID _____

Telephone number_____

Birthdate_____

_____ Tuberculosis Test Result. Must be read in millimeters and interpretation must follow the CDC guidelines.

Date applied: _____

Date read: _____Result: _____(mm) Interpretation: Pos or Neg

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

_____ _____

Physician Signature Date

Physicians Name (Print)_____

Name of Practice _____

Address _____

Phone_____