



TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER™
at El Paso

Occupational Health Services

4801 Alberta Ave. El Paso, Texas 79905
Phone: (915) 521-4429 Fax: (915) 545-6680

TUBERCULOSIS SCREENING FORM

Last Name: _____	First Name: _____
Date of Birth: ___ / ___ / _____	Department: _____

This form is to be completed by all employees, volunteers, students and others who:

- Are New Texas Tech employees and do NOT work in “High Risk” clinics. (Internal Medicine and Family Medicine clinics are considered “High Risk”).
- Have or have had a positive TB skin test (TST)
- Have had treated active TB

Have you had any of the following symptoms for more than three weeks at a time?

- | | |
|---|---|
| <input type="checkbox"/> No symptoms | |
| <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Blood-tinged sputum when you cough |
| <input type="checkbox"/> Unexplained fever | <input type="checkbox"/> Unexplained weight loss |
| <input type="checkbox"/> Unexplained night sweats | <input type="checkbox"/> Unexplained general fatigue |

To the best of my knowledge, the above statements are correct and complete and may be used to whatever extent necessary in connection with employment or other Texas Tech activity.

Fax completed form to Occupational Health Services (915) 545-6680.

Print Name

Signature

Today's Date