# LOS ANGELES UNIFIED SCHOOL DISTRICT
## OFFICE OF THE CHIEF MEDICAL DIRECTOR
## EMPLOYEE HEALTH SERVICES
## TB COMPLIANCE PROGRAM

**Name:** _____ **Date of Birth:** _____

**Job Title:** _____ **Phone:** _____

**Social Security No.:** _____ **or Employee No.:** _____ **Email Address:** _____

# TUBERCULOSIS CERTIFICATE OF COMPLETION

**Check One:**

☐ The patient does not have TB risk factors per the ***ADULT TUBERCULOSIS RISK ASSESSMENT*.**

☐ The patient had a negative skin or blood test on _____ (date).
**APPLICANTS:** Date of test must be within 60 days prior to date of hire.

☐ The patient had a positive skin or blood test, followed by a negative chest x-ray on _____ (date).
**APPLICANTS:** Date of x-ray must be within six months prior to date of hire.

*The above named patient does not have risk factors, or if risk factors were identified, the patient has been examined and determined to be free of infectious tuberculosis.*

| | | |
|---|---|---|
| Health Care Provider's Signature (MD, DO, PA, NP, RN Only) | | Date |
| Print Health Care Provider's Name | Title | License No. |
| Address | City | Zip Code |
| Telephone | Fax | |

**RETURN ORIGINAL COMPLETED FORM TO:**
**LAUSD Employee Health Services – TB Compliance Program**
**333 S. Beaudry Avenue, 14-110, Los Angeles, CA 90017**
**Phone: (213) 241-6326 Fax: (213) 241-8918**
**E-mail: employeehealth@lausd.net**

***Refer to http://publichealth.lacounty.gov/TB* for more information.**

**MEDICAL FACILITY STAMP (REQUIRED):**