West Virginia Department of Human Services

CHILD CARE PROVIDER TB Screening/Risk Assessment

Name of Provider:_____ **Date of Birth**: _____
(Last) (First) (Middle)

TB Screening Status

Tuberculosis shall be controlled by requiring the provider and staff to have an acceptable TB Screening.

Please Check One:

☐ **This patient has had a TB Risk Assessment.** **Date of Assessment: _____**

☐ **This patient has a negative TB test.** **Date of test: _____**

☐ **This patient is low risk for acquiring TB. Testing is not recommended.**

☐ **This patient has a positive TB test or has had TB disease and is now free of any signs and symptoms of active TB and is cleared to work with children.**

☐ **This patient is not cleared to work with children.**

☐ **This patient is cleared to work with children.**

Signature of Healthcare Professional _____Exam Date: _____

Healthcare Professional Name: (please print)_____