



271 East First Street
Corning, NY 14830
607-962-8225/1-888-962-8244
Fax 607-962-2592

Tuberculosis Test Form

Name: _____ D. O. B.: _____

Date test was administered: _____

Site: _____

Facility where test was administered: _____

Manufacturer: _____ Lot/Exp. Date: _____

Administered by: _____

Date test was read: _____

Test results: _____

Read by: _____

Facility where test was read: _____

Additional follow-up needed? Y N

If yes please describe: _____

Chest X-ray date (if applicable): _____

Chest X-ray results: _____

Chest X-ray results reviewed by: _____

Further follow-up needed: (if applicable) _____
