



# PHJC Volunteers

*Make a difference with heart!*

## RESULT OF TUBERCULIN TEST

*(REQUIRED BEFORE VOLUNTEER MAY BEGIN SERVICES.)*

Name of Volunteer: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Lot # \_\_\_\_\_

Results of Tuberculin skin test:                      Positive                      Negative

   Or Chest X-Ray:                      Positive                      Negative

Date Administered: \_\_\_\_\_ Date Results Read: \_\_\_\_\_

Signature\*: \_\_\_\_\_ Credentials: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**\*This statement may only be signed by a licensed physician, advanced practice registered nurse or nurse practitioner.**