Dinwiddie County Public Schools
14016 Boydton Plank Road / P.O. Box 7
Dinwiddie, Virginia 23841

PHYSICIAN'S TUBERCULOSIS CERTIFICATION FOR EMPLOYEES OF DINWIDDIE COUNTY PUBLIC SCHOOLS

"As a condition to employment, every public school employee, including without limitation teachers, cafeteria workers, janitors and bus drivers, shall submit a certificate signed by a licensed physician, or by a registered nurse licensed pursuant to Article 2 (§ 54.1-3016 et seq.) of Chapter 30 of Title 54.1, stating that such employee appears free of communicable tuberculosis. Such certificate shall be based on recorded results of such skin tests, X-rays and other examinations, singly or in combination, as are deemed necessary by a licensed physician that have been performed within the twelve months' period immediately preceding submission of the certificate. After consulting with the local health director, any school board may require the submission of such certificates annually, or at such intervals as it deems appropriate, as a condition to continued employment."

Code of Virginia § 22.1-300

Name of Employee _____ **Sex** _____ **Birth Date** _____

Address of Employee _____

_____

In compliance with State law, on the basis of chest x-ray, tests and/or examinations, I hereby certify that the above named is believed free of communicable tuberculosis as of this date.

Signature of Health Care Provider _____

Address of Health Care Provider _____

_____

Phone Number of Health Care Provider _____

Date of Examination _____

I am a licensed health care provider in _____, United States of America.
(State or District)

This form MUST be returned to the Human Resources Department, Dinwiddie County Public Schools

VIRGINIA DEPARTMENT OF HEALTH
REPORT OF TUBERCULOSIS SCREENING

Name_____ Date of Birth_____ Date_____

TO WHOM IT MAY CONCERN: The above individual has been evaluated by: _____
*(**PLEASE PRINT** name of health department, facility or clinician)*

TB Screening and/or Testing Conclusions

I. No Symptoms nor Other Risks Identified on TB Risk Assessment

_____ A tuberculin skin test (TST) or blood test (IGRA) is not indicated at this time due to the absence of symptoms suggestive of active TB, no risk factors identified for infection or for developing active TB if infected, and has no known recent contact with active TB. Health care workers employed in a low risk facility according to CDC "Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005" do not need testing.

_____ The individual has a history of TB infection. Follow-up chest x-ray is not indicated at this time due to the absence of symptoms suggestive of active TB.

If neither applies, go to section II.
If in a health-care setting that *requires* a test for TB infection but no symptoms are present, go to section III.
If one of these two statements applies, select the appropriate statement and skip to Section V and select statement 'A'.

II. Symptoms Consistent with Potential Tuberculosis are Present

Call the local health department to refer the person for further TB evaluation immediately. This notification is necessary even when the individual prefers to pursue an evaluation privately. Proceed to Section V and select statement 'B.' If there are no symptoms consistent with TB, go to Section III.

III. Testing for TB Infection – Choose TST or IGRA

Tuberculin Skin Test (TST): (record both tests if a 2-step TST was required)
Date given: _____ Date read: _____ __ Results: _____mm Interpretation: _____ negative _____ positive
Date given: _____ Date read: _____ __ Results: _____mm Interpretation: _____ negative _____ positive

Interferon Gamma Release Assay (TB infection blood test):
Date drawn:_____ Test done: _____T-Spot TB _____ Quantiferon TB Gold
Result: _____ negative _____ positive _____ indeterminate _____borderline _____ invalid

If test above is negative, proceed to Section V and select statement 'A'. If either test for TB infection is positive, proceed to Section IV,

IV. Chest X-Ray to Evaluate for Potential TB Disease

Date of chest x-ray_____ Location of chest x-ray: _____
Interpretation: _____
_____ no evidence of active tuberculosis
_____ chest x-ray abnormal, active tuberculosis to be ruled out

V. TB Screening/Testing Conclusion

_____ A. Based on the TB Screening and/or further testing, the individual listed above is free of communicable tuberculosis in a communicable form.
_____ B. Active tuberculosis cannot be ruled out in the individual listed above. The individual has been referred to their physician and the local health department for further evaluation.

Signature _____ _____ Date _____ Phone _____
(Clinician with prescriptive authority or health department official)

Address _____

_____