KENNESAW STATE UNIVERSITY
WELLSTAR COLLEGE OF HEALTH AND HUMAN SERVICES
School of Nursing

TB Testing

Name: _____ Date of Birth_____

KSU ID #_____ Phone Number _____

KSU E-mail _____ Current Course # _____

*QuantiFERON Gold date ____/_____/____ Results: _____ (copy of lab report required)

OR

*T-Spot date ____/_____/____ Results: _____ (copy of lab report required)

OR

*Chest x-ray date ____/_____/____ (copy of x-ray report required)
(*only if QuantiFERON Gold or T-Spot reading is positive*)

* Treatment for latent TB, please include medication dose, frequency and duration:

_____

_____

Health Care Provider's Signature:_____ Date:___/_____/____

Health Care Provider's Name: (Print) _____

Address:_____

Telephone Number: _____