

**CLEVELAND STATE UNIVERSITY  
SCHOOL OF HEALTH SCIENCES**

To be completed by a physician/nurse practitioner.

Please indicate which program:

DPT       MOT       CSD

**TUBERCULOSIS SCREENING**

**Tuberculosis Screening** - The two-step TB Mantoux Test report is required for all students entering the program followed by ANNUAL two-step updates throughout the program. **If a student has tested positive for TB, a chest X-Ray is required annually. The results of the Two-step TB Mantox Test or Chest X-Ray should be indicated on this Tuberculosis Screening Form.** The School of Health Sciences will also accept Quantiferon blood test results.

Student Name: \_\_\_\_\_

CSU ID Number: \_\_\_\_\_

**TWO-STEP MANTOUX TEST**

**STEP ONE:**

**STEP TWO (performed 1-3 weeks after Step 1):**

Date administered: \_\_\_\_\_ Date administered: \_\_\_\_\_

Date read: \_\_\_\_\_ Date read: \_\_\_\_\_

Results:     Positive     Negative    Results:     Positive     Negative

**OR**

**QUANTIFERON:**

Date drawn: \_\_\_\_\_

Results:     Positive     Negative

**OR**

**CHEST X-RAY: If chest x-ray is needed, you must attach a copy of the results with this form. Documentation must include date X-ray was read and the name and credentials of the individual who read the X-Ray. X-Ray must be repeated annually.**

Physician' s/Nurse Practitioner's Name (Please Print)

Office Address

City, State, Zip Code

**This information must be legible and include professional credentials.**

Physician/Nurse Signature

Date

**Stamp required in the Box on  
the Right for Validation:**

