SUMMIT HEALTH CREDENTIALS VERIFICATION ORGANIZATION
THE CHAMBERSBURG HOSPITAL
PROVIDER RESOURCES
CHAMBERSBURG PA 17201

Name: _____ Date: _____

According to the Tuberculosis Screening for Employees/Physicians policy of Summit Health, you are required to report your TB status at the time of initial appointment, and **annually** complete the signs and symptoms question below.

**You may make your own arrangements with a health care provider for TB testing, or the Employee Health Coordinator will provide the testing at either hospital at no cost.**

- ✓ **Chambersburg 717-267-7518**
- ✓ **Waynesboro 717-765-4000 ext 5203**

## PLEASE COMPLETE ONE OF THE FOLLOWING SECTIONS:

### INITIAL APPOINTMENTS

**NEGATIVE REACTORS -- ATTACH A COPY OF YOUR TB SCREENING FORM (DONE WITHIN THE PREVIOUS TWELVE MONTHS) COMPLETED BY A HEALTH CARE PROVIDER OTHER THAN YOU.**

Date of test: _____ Date to be read (48 – 72 hours): _____
Administered by: _____

RESULT OF TEST – CHECK ONE:

- ❑ Non-significant (no palpable area of induration)
- ❑ Significant (any palpable area of induration) Measurement _____

Person reading test: _____ Date: _____

**POSITIVE REACTORS** -- Health care providers will screen individuals who have a history of a **positive TB test** for signs and symptoms of TB. A chest x-ray is required if you are symptomatic. Please answer the following question:

"Have you noted a persistent hoarseness or cough, unexplained fever, night sweats or weight loss within the last year?"
YES _____ NO _____ Date of Test: _____
*** NOTE** -- If you answered, "YES," you must contact your personal physician who will order a chest x-ray and provide follow-up.

Signature: _____ Date: _____

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### ANNUALLY

Health care providers will screen individuals, ANNUALLY for signs and symptoms of TB. A chest x-ray is required if you are symptomatic. Please answer the following question:

"Have you noted a persistent hoarseness or cough, unexplained fever, night sweats or weight loss within the last year?"
YES _____ NO _____ Date of Test: _____
*** NOTE** -- If you answered, "YES," you must contact your personal physician who will order a chest x-ray and provide follow-up.

Signature: _____ Date: _____

PLEASE RETURN FORM TO:
SUMMIT HEALTH CREDENTIALS VERIFICATION ORGANIZATION
**FAX NO: 717-267-4806**
CHAMBERSBURG PA 17201

Updated: 04/2015