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: ____________________________

*** O R ***

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