7701 Grand River Suite 100 - Brighton, MI 48114
Phone (810) 227-7544 Fax (810) 225-4003

Annual Tuberculosis Surveillance Screen

This information is being sought in connection with TB evaluation process only and will be kept confidential and not used for any other purpose. This form will be forwarded to the Human Resources Department for inclusion in your personnel medical file.

Employee Name: ____

Position: ____

Please return by: ____

Please answer the following questions. Do not leave a blank. If you do not understand a question, please have it clarified. Your supervisor will assist you.

A. In the past year, have you experienced any of the following symptoms?

	Yes	No
1. Chronic cough		
2. Night sweats		
3. Unexplained weight loss		
4. Loss of appetite		
5. Fever		
6. Fatigue		
7. Weakness		
8. Hemoptysis (coughing up blood)		

If yes, please explain: ____

____

B. Do you know of any exposure to an active TB client in the last year?

Yes_______ No_______ Uncertain_______

Employee Signature: ______________________________ Date: __________

DO NOT WRITE BELOW THIS LINE

Interview comments/results: ____

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Signature RN Reviewer: ______________________ Date: ______________