Clear Form

KernMedical

Tuberculosis Screening

Employee Health Services

Main: (661) 326-2608 | Fax: (661) 862-7673 | Email: employeehealth@kernmedical.com

Name: _____ **Department:** _____

DOB: _____ **Email Address:** _____ **Phone**: _____

- TB screening (including completion of this questionnaire) is required at Kern Medical (1) as part of the onboarding process for all associates and (2) on an annual basis for all associates.
- Please answer the questions below; sign and date the form. Email completed form to employeehealth@kernmedical.com You will be notified if additional information or further action is needed.

I have a history of a positive TB skin test, Quantiferon or T Spot Blood Test. ◯ **No** ◯ **Yes**
If yes, include the date: _____

I have taken INH or other medication in the past for TB infection or disease. ◯ **No** ◯ **Yes**
If yes, include the date: _____ *Number of months:* _____ *Medication(s):* _____

I was born, have resided, or traveled in a foreign country for at least 1 month. ◯ **No** ◯ **Yes**
*If yes, list the countries***:** _____

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1. **Do you have or have you had:**
   - *Recent contact with a person who has active Tuberculosis* ◯ Yes ◯ No
   - *Any condition that decreases your immune system* ◯ Yes ◯ No
   - *An organ transplant* ◯ Yes ◯ No
2. **Since your last TB test, have you had any of the following <u>active</u> TB symptoms for more than 3 weeks?**
   - *Coughing up blood* ◯ Yes ◯ No
   - *Persistent coughing* ◯ Yes ◯ No
   - *Excessive fatigue* ◯ Yes ◯ No
   - *Excessive sweating at night* ◯ Yes ◯ No
   - *Persistent fever* ◯ Yes ◯ No
   - *Hoarseness* ◯ Yes ◯ No
   - *Unexplained weight loss* ◯ Yes ◯ No

Signature_____**Date**_____

<u>Employee Health Only</u>

Rev. 4/10/2024