



Physician: _____

Resident: _____ DOB: _____

In order to remain in compliance with New York State Department of Health Regulations, please complete ONE of the choices below regarding the above-named patient /resident for PPD test. And complete the Covid vaccination at the bottom.

PHYSICIAN STATEMENT

A tuberculosis skin test (TST) / PPD/ Mantoux test has been performed.

Date placed: ___ / ___ / ___ Area of PPD _____ Lot # _____ Exp: _____

Signature: _____

Date read: ___ / ___ / ___ Results _____

Signature: _____ Title: _____

Physician Signature

Date

COMPLETE THIS BOX ONLY IF POSITIVE RESULT

PHYSICIAN STATEMENT

The resident named above, is known to me. Based on past medical history and physical examination active tuberculosis infection has been ruled out. In my medical opinion, this resident does not require a Tuberculosis skin test (TST) / Mantoux test / PPD test.

Physician Signature

Date

Do you as the PCP recommend a second TST/PPD within 30 day after admission? ___ Yes ___ No

COVID Information

Covid -19 Vaccination ___ Yes ___ No Manufacture _____

Dose 1: Date _____ Lot# _____ Administered _____

Dose 2: Date _____ Lot# _____ Administered _____

Dose 3: Date _____ Lot# _____ Administered _____