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. The PPD test must be completed within 30 days of the admission date.
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____________________________________

Dose 4: Date___________ Lot#______________ Administered____________________________________

Dose 5: Date___________ Lot#______________ Administered____________________________________

Dose 6: Date___________ Lot#______________ Administered____________________________________