Student Name: ____________________________ Birthdate (MM/DD/YY): ____________________________

If you are an entering Geisel School of Medicine Student you must complete ONE of the following:

- TWO TSTs administered 7-21 days apart (If 1st TST is POSITIVE, please go directly to section B).
- IGRA or QuantiFERON Gold within 6 months of program start (results must be attached and translated into English).
- T-SPOT test within 6 months of program start (results must be attached and translated into English).

**Section A** - To be completed by healthcare provider (If positive result, proceed to section B)

- TB testing is required even if you have had the BCG vaccine
- A test >10mm is considered positive TB from high prevalence countries, >5mm if you are immunocompromised

PPD test #1: Date Planted: __________ Date Read: __________ Induration: _______ mm Read within 48-72 hours PPD
   test #2: Date Planted: __________ Date Read: __________ Induration: _______ mm Read within 48-72 hours

__________________________________________  ____________________________________________  ________
Signature of Provider MD/PA/APRN/RN          Printed Name                                      Date

**Section B** - To be completed by healthcare provider in the event of positive Tuberculosis test OR history of Tuberculosis.

1. If you have a POSITIVE TST, T-SPOT or IGRA (QuantiFERON Gold); Please complete a CHEST X-RAY
2. Attach a copy of a report for a chest x-ray that was taken upon or after the positive result.
   This chest x-ray or MUST be written or officially translated into English and dated within 6 months of entrance to Dartmouth.
3. Did the student receive tuberculosis therapy? YES  NO
   a. If yes, please provide the following:
   b. Start Date: ______________ Completion Date: ______________ Type (Medication):

   ______________________________________________________

4. Provide a clinical evaluation. Does the patient exhibit cough, hemoptysis, fever, chills, night sweats or weight loss?
   Yes ___ No ___ If yes please describe: ____________________________________________

__________________________________________  ____________________________________________  ________
Signature of Provider MD/PA/APRN/RN          Printed Name                                      Date