Proof of TB Screening Test

(Skin Test, Blood Test, or Chest X-Ray)

**I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have been requested by CareKnots** **to provide proof of a current TB screening test throughout my tenure of caregiving services, in line with CareKnots Tuberculosis Prevention Policy. I understand that this screening test is necessary to ensure that our clients are being protected and to protect caregivers who care for clients who are Tuberculosis positive. I further understand that proof of a current TB screening test is a part of the key selection criteria for continuing caregiving services with The Client.**

\_\_\_\_ I have received my TB skin test and will provide proof upon interview.

\_\_\_\_ I do not have a current TB skin test and will have the TB test before I begin caregiving services.

I have chosen not to receive the TB skin test for:

* Medical reasons; I will provide documentation from my physician
* Other reasons: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therefore, in lieu of the TB skin test, I will comply with **CareKnots** TB Prevention Policy and obtain a:

* TB screening blood test, e.g., an Interferon Gamma Release Assay or
* TB screening chest x-ray

\_\_\_\_ I will provide current documentation from my physician of this screening upon caregiving services.

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Caregiver Name (printed) Caregiver Signature Date

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CareKnots Representative Name and Title CareKnots Representative Signature Date