

Certificate of Completion Tuberculosis Risk Assessment and/or Examination

To satisfy job-related requirements in the California Education Code, Sections 49406 and 87408.6 and the California Health and Safety Code, Sections 1597.055, 121525, 121545 and 121555.

First and Last Name of the person assessed and/or examined:

Date of assessment and/or examination: _____ mo./ _____ day/ _____

Date of Birth: _____ mo/- _____ day/- _____ y

The above named patient has submitted to a tuberculosis risk assessment. The patient does not have risk factors, or if tuberculosis risk factors were identified, the patient has been examined and determined to be free of infectious tuberculosis.

Signature of Health Care Provider completing the risk assessment and/or examination

Please print, place label or stamp with Health Care Provider Name, Address (include Number, Street, City, State, and Zip Code):

Telephone/FAX: