5202 Pinemont Drive
Salt Lake City, Utah 84123
Email: accreditation@nafcc.org

Phone: (801) 269-9338
Fax: (801) 268-9507
Website: www.nafcc.org

Family Child Care TB Screening

Patient completes this section

Name: ____ **Telephone:** (_____) ________________

❑ ***Child Care Provider*** ***or*** ❑ ***Assistant***

____

Address **City** **State** **Zip**

TB screening status completed & signed by a health care professional

Tuberculosis shall be controlled by requiring the provider and provider assistants to have an acceptable TB screening. Please check one.

❑ **This patient has a negative TB test.** **Date of test:** ____________________

❑ **This patient is low risk for acquiring TB. Testing is not recommended at this time.**

❑ **This patient has a positive TB test or has had TB disease and is now free of any signs and symptoms of active TB and is cleared to work with children.**

❑ **This patient is not cleared to work with children.**

Signature of health care professional: ____________________________________ **Date:** ____________

Name: ____ **Telephone:** (_____) ________________

____

Address **City** **State** **Zip**

NOTE: The TB Screening must be dated within 2 years prior to when the request for observation visit documentation is complete.