LSU Health New Orleans
HEALTH SCIENCES CENTER

PPD SCREENING

(This form should be completed by your health care provider)

Name of applicant: _____ **Date:** _____

Provide documentation of PPD testing within the past 12 months:

Date: _____ **PPD Result:** _____ **mm**

If PPD positive, document:

1) **Date of positive PPD testing:** _____

2) **Treatment:** _____ **Dates:** _____

3) **Chest X-Ray:** _____ **Dates:** _____
Results within past 24 months

_____ _____
Screening Practitioner's Name (Print) **Date**

_____
Screening Practitioner's Signature

Are you currently experiencing any of the following symptoms:

	Yes	No
• Fever	☐	☐
• Cough	☐	☐
• Recent Weight Loss	☐	☐
• Hemoptysis	☐	☐

_____
Applicant's Signature