



# Student Tuberculosis (TB) Attestation

## Mayo Clinic College of Medicine and Science (MCCMS)

Form content not retained in medical record. To be scanned into MCCMS Student Records.

### Student Information

Name (First Middle Last)	Birth Date (mm-dd-yyyy)
Program Name	Program Start Date (mm-dd-yyyy)

### Provider

This program requires documentation of tuberculosis status. The recommended method of testing is by Interferon-Gamma Release Assay (IGRA). Test must be done within 3 months prior to program start. Lab report must be submitted with the completed form.

IGRA Blood Test	Test Date (mm-dd-yyyy)	Result
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### Alternate Option

If blood test is unavailable, the student may submit two TB skins (PPD) tests. The first test must be dated not more than 12 months prior to program start. The second test must be within 3 months prior to program start. Tests must be administered a minimum of 7 days apart.

Skin Test One	Date Placed (mm-dd-yyyy)	Date Read (mm-dd-yyyy)	Result (mm)
Skin Test Two	Date Placed (mm-dd-yyyy)	Date Read (mm-dd-yyyy)	Result (mm)

### Complete this section ONLY if the student has, or has had, a positive TB test.

- If a skin test has been positive (greater than 10 mm), a blood test is required.
- If a blood test (IGRA) is positive, a chest x-ray (posteroanterior and lateral) is required.
- A TB risk assessment, and signs and symptoms screening must be performed.
- Lab and radiology results must be submitted with this completed form.

Positive Skin Test Date (mm-dd-yyyy) (if applicable)	Result (mm)
Positive IGRA Date (mm-dd-yyyy)	Was treatment completed?
Chest X-Ray Date (mm-dd-yyyy)	Chest X-Ray Result (attach interpretive report)

### I attest that the above named student has completed a baseline screening and does not have infectious tuberculosis.

Healthcare Provider Signature ▶	Date (mm-dd-yyyy)
Healthcare Provider Printed Name (First Middle Last)	<input type="checkbox"/> Physician <input type="checkbox"/> NP <input type="checkbox"/> PA
License Number	State
Healthcare Facility Name	Healthcare Facility Address (Street, City, State, ZIP Code)

### Student Signature

I understand and authorize the provided medical information in this form will be stored in a database not related to my electronic medical record and may be accessed by non-medical providers. It is my responsibility to maintain copies of this form for future educational requirements. **If the student is 17 years of age or younger, or a minor under state law, the student's parent or legal guardian must sign and date the form.**

Student or Authorized Representative Signature (required) ▶	Date (required) (mm-dd-yyyy)
Authorized Representative Printed Name (if applies) (First Middle Last)	