



Tuberculosis Screening Questionnaire

Name: _____ Date of Birth: _____

Phone Number: _____ Email Address: _____

Instructions: This confidential tuberculosis (TB) screening is required annually for UW Health staff and providers who work at a patient care location and/or who have a history of a positive TB screening test. Based on your responses, you may be contacted by an Employee Health Services nurse to obtain more information.

Table with 3 columns: Question, No, Yes, please describe. Contains 7 screening questions regarding symptoms, exposure, travel, and immunosuppression.

My responses on this form are true and correct to the best of my knowledge.

Non-Employee Signature

Date

Return completed and signed form to: Fax: (608) 262-7284 or Email: hremLOYEEhealth@uwhealth.org

EHS USE ONLY

- Checkboxes for: This person does not have symptoms of active TB disease or risk factors for being exposed to TB. No further evaluation is needed. QFT required. Individual and EHS Onboarding Specialist notified.

EHS staff signature

Date