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Physician Certification Form for 2-step TB Test

Office of Field Services
102 Stevens Hall
814.393.2144

For Mid-level and Secondary Education Majors Only

Student's name_____ Student ID _____

Telephone number_____

Birthdate_____

_____ 2-Step Tuberculosis Test Result. **Must be read in millimeters** and interpretation must follow the CDC guidelines.

1st step: Date read: _____Result: _____(mm) Interpretation: Pos or Neg

2nd step: Date read: _____Result: _____(mm) Interpretation: Pos or Neg

I certify that to the best of my knowledge the information above is full, complete, and true.

_____ _____
Physician Signature Date

Physicians Name (Print) _____

Medical Licensure No. _____

Name of Practice _____

Address _____ Phone_____

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