

**School of Education**

**Office of Clinical Experiences and Student Services**

**Application - Tuberculosis Test**

|  |
| --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Last Name First Name MI SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_ \_\_\_\_/\_\_\_\_\_/\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Male Female Age DOB (MM/DD/YY) Race |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Street Address, City, State & Zip  Telephone: *Home:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Work:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *Cellular Phone:*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| Requested for (please check one) Fall\_\_\_\_\_ Spring\_\_\_\_\_ Year\_\_\_\_\_  On the basis of chest X-ray, test, and/or examinations, I hereby certify that the student identified at the top of this page is diagnosed to be free of communicable tuberculosis as of the date below.  I am a licensed physician in \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (State or District), United States of America  Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Adress:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Telephone: \_\_\_(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Virginia State Law requires the education candidate to return this TB Certification to the Office of Clinical Experiences and Student Services prior to the field experience.  The test is to be effective through the entire field experience. |