TB Form F: State of Hawai'i TB Clearance Form

Hawai'i State Department of Health
Tuberculosis Control Program

Patient Name	DOB	TB Screening Date

I have evaluated the individual named above using the process set out in the DOH TB Clearance Manual and determined that the individual does not have TB disease as defined in the Hawai'i Administrative Rules 11-164.2.

I. Screening for schools, child care facilities, or food handlers *(TB Document A,A.2 or E)*

☐ Negative TB risk assessment
☐ Negative test for TB infection: TST: mm, date read: ; or QFT date:
☐ Positive test for TB infection: TST: mm, date read: ; or QFT date: and negative chest X-ray (date:)

II. Initial Screening for Health Care Facilities or Residential Care Settings (*TB Document B, B.2, C, C.2)*

☐ Negative Risk Assessment: Children 1-17 yrs old, who are household members in adult residential care settings
Adults and Pediatric clients / patients living or working in a DOH licensed facility: ☐ Negative test for TB infection (2-step TST or QFT; or single TST/symptom screen plus negative CXR): TST #1: mm, date read: TST #2: mm, date read: **or** QFT date: Single TST: mm, date read: Symptoms Screen date: Negative chest X-ray date:
☐ New positive TB test: TST: mm; date read: or QFT date: Negative CXR date:
☐ Previous positive test for TB infection: ☐ negative symptoms screen, date: ☐ negative risk assessment, date: ☐ negative CXR within previous 12 months: Date of CXR:
☐ Previous positive test for TB infection, and negative CXR: Date of CXR:

III. Annual Screening for Health Care Facilities or Residential Care Settings (*TB Document D, D.2)*

☐ Negative risk assessment and negative symptom screen (Persons working in Health Care Facilities
☐ Negative test for TB infection: TST: mm, date read or QFT date:
☐ New positive test for TB infection: TST: mm, date read: or QFT date: and negative chest X-ray (date:)
☐ Previous positive test for TB infection and negative symptoms screen

Signature or Unique Stamp of Practitioner: _____
Printed Name of Practitioner (MD/DO/APRN/NP/PA): _____
Healthcare Facility: _____
Address: _____
Phone Number: _____ Fax: _____

This TB clearance provides a reasonable assurance that the individual listed on this form was free from tuberculosis disease at the time of the exam. This form does not imply any guarantee or protection from future tuberculosis risk for the individual listed.