FDNY BUREAU OF HEALTH SERVICES

CANDIDATE TUBERCULOSIS QUESTIONNAIRE AND INFORMED CONSENT TO ADMINISTER PPD SKIN TEST - BHS FORM 3A

CANDIDATE INFORMATION

Name (Last, First):	Last Four Digits of Social Security:	Date of Birth (MM/DD/YYYY):	Civil Service Title:

INSTRUCTIONS

FDNY personnel could potentially be exposed to emergency victims or other persons who have Tuberculosis (TB). Tuberculosis (TB), a contagious bacterial infection that involves the lungs, but may spread to other organs. TB is a treatable disease that can be diagnosed with a skin test, called a PPD Skin test.

You are required, to the best of your knowledge, to fully and accurately respond to all questions listed below. Carefully read all items listed below. Check "Yes" if you have *ever had* the condition, medical procedure, or status for each item listed below. Check "No" if, to the best of your knowledge, you have *never had* the condition, medical procedure or status for each item listed below.

You are also required to comply with the "Instructions to Candidates" found on ***BHS Form 3B***, a copy of which will be given to you.

QUESTION	YES	NO
Have you ever been diagnosed with TB?		
Have you been given the PPD Skin Test within the last six (6) months?		
If foreign born, have you ever received a TB vaccination as a child?		

INFORMED CONSENT

The PPD Skin Test is performed by injecting a very small amount of tuberculin purified protein derivative (PPD) into the inner surface of the forearm. The injection will be made with a tuberculin syringe. ***If I am pregnant, have had an immunosuppressive condition, recent vaccine history, a history of a previous positive PPD test, or am sick now, I should discuss this with the test administrator before proceeding.*** If the area of injection is palpable, raised, hardened or swollen, during the period between 48 and 72 hours after the PPD Skin Test is administered, this may be a sign that I have tested positive for TB. ***If the PPD Skin Test indicates that I have TB, I understand that I should seek any appropriate medical treatment from a licensed medical services provider of my choice.*** A positive test result does not mean that I am automatically disqualified from appointment because treatment is available.

I have read and understand the instructions found above. I have also read and understand the "Instructions to Candidates" found on ***BHS Form 3B***. I have had the opportunity to have my questions answered.

SIGNATURE:_____ DATE: _____

(Do Not Write Below This Line – To Be Completed By FDNY – Bureau of Health Services Personnel Only)

DOCUMENTATION OF TB TEST

Candidate Name (Last, First):		
Test Administered By:		
Dose:	**Site of Test (circle):** **Right Arm / Left Arm**	
Signature of BHS Personnel Who Administered Test:		**Date of Test (MM/DD/YYY):**

DOCUMENTATION OF TEST RESULTS

Date of Observation (MM/DD/YYYY):	RESULT: Negative ☐ Positive ☐ MM Induration:	Signature of BHS Personnel Who Observed Test Results: