FDNY BUREAU OF HEALTH SERVICES

OBSERVATION OF TUBERCULOSIS TEST RESULTS
BHS FORM 3B

The candidate for FDNY employment noted below has been administered the PPD Skin test for Tuberculosis on the date stated above, and s/he is required to obtain a reading of the test results by a licensed medical services provider. Please complete the bottom portion of this form or provide the test results on your letterhead. Your office may return the test results to the Candidate or you may fax them directly to the FDNY Bureau of Health Services at 718-999-0087.

If you have any questions regarding this matter, please call the Bureau of Health Services at 718-999-1870.

Thank you for your cooperation.

CANDIDATE INFORMATION
(To be completed by Candidate)

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

DOCUMENTATION OF TEST RESULTS
(To Be Completed By a Licensed Medical Services Provider)

Date of Observation (MM/DD/YYYY):	Result: Negative ☐ Positive ☐ MM Induration:
Action Taken If Result Is Positive:	
Signature:	**Printed Name:**
Office Address:	
License/Registration Number:	

INSTRUCTIONS TO CANDIDATES

You are required to receive the PPD Skin Test as part of your medical assessment ***and*** to ensure that the FDNY Bureau of Health Services (BHS) obtains the results of the PPD Skin test. ***The results of the PPD Skin test must be confirmed during the period between 48 and 72 hours after the PPD Skin test is administered,*** by BHS ***or*** by a licensed medical services provider of your choice.

If you wish to have BHS confirm the results of your PPD Skin test, you may do so by visiting BHS on Monday through Friday, during the hours of 8:00 AM through 11:00 AM and 1:00 PM through 3:00 PM, and ***between 48 and 72 hours after the PPD Skin test is administered***.

If you wish to have a licensed medical services provider of your choice confirm the result of the PPD Skin test, the licensed medical services provider must complete this form ***or*** provide the information required below under the licensed medical services provider's letterhead. The form must be faxed to BHS (at 718-999-0087) or delivered to BHS no later than ***seven (7) calendar days*** from the date of your TB test.

To: **Medical Services Provider**

From: **Bureau of Health Services**
NYC Fire Department

Date: _____

Re: **Observation of Tuberculosis Test Results**