

CARING PROFESSIONALS, INC.
70-20 AUSTIN STREET, SUITE 135
FOREST HILLS, NY 11375
718-897-2273

ANNUAL PPD (MANTOUX)

EMPLOYEE NAME: _____ RN/LPN/HHA/PCA

ID# _____ PHONE: _____

DATE PPD IMPLANTED _____

DATE PPD READ _____

MANUFACTURER _____ LOT # _____

RESULTS: NEGATIVE _____ mm POSITIVE _____ mm

Alternative to PPD testing:

WHOLE BLOOD ASSAY TEST FOR T.B. **(must attach lab report!)**

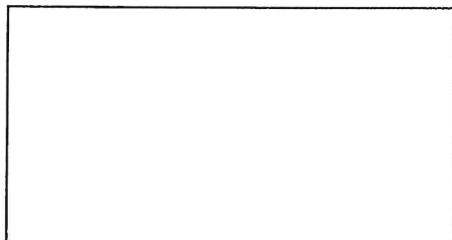
DATE DRAWN: _____

RESULTS: _____ (NEGATIVE/POSITIVE)

CHEST X-RAY (Mandatory **ONLY** if current PPD/Blood Assay is positive)

DATE: _____ RESULTS: _____ (please attach report)

GIVEN BY _____ (SIGNATURE AND TITLE)



(PLEASE USE DOCTOR'S STAMP)