VIRGINIA BEACH CITY PUBLIC SCHOOLS
CHARTING THE COURSE

Department of Human Resources
Quality • Diversity • Passion • Commitment

TUBERCULOSIS SCREENING CERTIFICATE

Section 1 – Completed By Employee/Applicant

Name: _____

Social Security Number: _____

Position: _____ **School/Department:** _____

Home Address: _____

Telephone: _____

*Section 2 – Completed By Authorized Individual**

On the basis of skin testing, x-ray, and other examinations, singly or in combination, I hereby Certify that the person listed in Section 1 is believed to be free of tuberculosis in a communicable form.

Date Test was Read _____

Physician's Signature _____ **Date** _____

Physician's Name (Printed or Typed)

_____

Address **Telephone**

_____

I am a licensed physician in _____ **, United States.**
State or District

***Code of Virginia, §22.1-300, Tuberculosis Certificate, requires that this certificate bear an official signature of a licensed physician. Listed below are the only signatures that will be accepted on this certificate.**

1. Doctor's signature.
2. Doctor's stamped signature PLUS nurse's signature or initials.
3. Doctor's stamped signature PLUS corpsman's signature or initials.
4. Doctor's stamped signature or RN's signature PLUS health department stamp.

****PLEASE RETURN TO THE DEPARTMENT OF HUMAN RESOURCES****

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