Applicant Name _____
(Last, First, Middle Initial)

Date of Birth_____/_____/_____ Medical Case Number:_____
(Mo/Day/Year)

Reactive Tuberculin Form
OMB No.: 0420-0550
Expiration Date: 1/31/2014

REACTIVE TUBERCULIN TEST EVALUATION FORM

Dear Medical Provider,

Your patient has applied to serve with the Peace Corps and has reported a history of reactivity to tuberculosis (TB) skin testing or a history of BCG vaccination. In order to accurately evaluate this applicant's medical status, the Peace Corps needs further information about the applicant's risk of developing tuberculosis. **Please answer the following questions regarding the applicant's TB status.**

Privacy Act Notice

This information is collected under the authority of the Peace Corps Act, 22 U.S.C. 2501 et seq. It will be used primarily for the purpose of determining your eligibility for Peace Corps service and, if you are invited to serve as a Peace Corps Volunteer, for the purpose of providing you with medical care during your Peace Corps service. Your disclosure of this information is voluntary; however, your failure to provide this information will result in the rejection of your application to become a Peace Corps Volunteer.

This information may be used for the purposes described in the Privacy Act, 5 USC 552a, including the routine uses listed in the Peace Corps' System of Records. Among other uses, this information may be used by those Peace Corps staff members who have a need for such information in the performance of their duties. It may also be disclosed to the Office of Workers' Compensation Programs in the Department of Labor in connection with claims under the Federal Employees' Compensation Act and, when necessary, to a physician, psychiatrist, clinical psychologist or other medical personnel treating you or involved in your treatment or care. A full list of routine uses for this information can be found on the Peace Corps website at http://multimedia.peacecorps.gov/multimedia/pdf/policies/systemofrecords.pdf.

Burden Statement:

Public reporting burden for this collection of information is estimated to average between 75 minutes to 105 minutes per applicant and 30 minutes per physician per response. This estimate includes the time for reviewing instructions and completing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: FOIA Officer, Peace Corps, 1111 20th Street, NW, Washington, DC 20526 ATTN: PRA (0420 - 0550). Do not return the completed form to this address..

Medical Case Number: _____

I. Current TB Test (Test must be within the past six months; Mantoux test or QuantiFeron-TB Gold) *(No test is required if there is documentation of the size of induration and there is documentation of treatment)*

Select one

☐ Mantoux Date: _____ mm of induration:_____

☐ Interferon Gamma Releasing Assay (QuantiFERON®-TB Gold)

Date:_____ Result: ☐ Positive ☐ Negative

☐ T.SPOT TB

Date:_____ Result: ☐ Positive ☐ Negative

II. TB Test History:

☐ No prior TB test

☐ Prior TB test(s)

Date:_____ mm of induration:_____

Date:_____ mm of induration:_____

Date:_____ mm of induration:_____

☐ BCG vaccine *(If reported by applicant, please provide)* Date of vaccination:_____

III. Current Tests Required

☐ Copy of current CXR report with interpretation is required for:

- Applicants with a reported induration or interval change in induration · 10mm
- Applicants with risk factors present (see Section V)
- Applicants with a history of a prior reactive tuberculin test
- Applicants with a history of BCG vaccination and a current reactive tuberculin test

☐ Copy of baseline Liver Functions Tests is required for:

- Applicants currently being treated for latent tuberculosis infection (LTBI)

IV. Treatment History:

Note: In general, treatment of latent tuberculosis infection (LTBI) is required for all Peace Corps applicants who are candidates for this therapy. Before an applicant can be medically cleared, and prior to departure overseas, treatment should be initiated in accordance with Centers for Disease Control (CDC) guidelines.[1] *There must be a strong medical reason for not treating preventively, e.g., high risk for hepatitis, etc.*

☐ No treatment received

☐ INH therapy received:

Date treatment initiated: _____ Ongoing: _____

Date treatment completed: _____

1 *Core Curriculum on Tuberculosis: What the Clinician Should Know,* 4th Edition, 2000. U.S. Department of Health and Human Services and Centers for Disease Control and Prevention.

Medical Case Number: _____

☐ Full-course of other treatment:

Drug regimen: _____ Date treatment initiated: _____

Ongoing: _____

Date treatment completed: _____

☐ Full-course or treatment not received:

Please explain: _____

_____

_____

_____

_____

V. RISK ASSESSMENT FOR DEVELOPING ACTIVE TB (Please check yes or no):

YES	NO	
☐	☐	Person infected with the human immunodeficiency virus.
☐	☐	Close contact (i.e., those sharing the same household or other enclosed environments) of person(s) known or suspected to have tuberculosis.
☐	☐	Foreign-born person who has recently arrived (within five years) from a country that has a high incidence or prevalence of tuberculosis (includes most countries in Asia, Africa, and Latin America).
☐	☐	Resident or employee of high-risk congregate setting (e.g., correctional institution, nursing home, mental institution, or shelter for the homeless).
☐	☐	Person who injects illicit drugs or uses other high-risk substances (e.g., crack cocaine).
☐	☐	Health care worker who is exposed to high-risk clients or is/has been mycobacteriology laboratory personnel.

VI. CURRENT TB SYMPTOMS:

YES	NO	
☐	☐	Cough lasting longer than three weeks
☐	☐	Night sweats (drenching bed clothes that last more than one week)
☐	☐	Unexplained weight loss of 10 pounds or more than 10 percent of normal weight
☐	☐	Fatigue/malaise lasting longer than two weeks
☐	☐	Loss of appetite > two weeks
☐	☐	Fever > 100 degrees lasting > one week

VII. RECOMMENDATIONS FOR FURTHER EVALUATION AND TREATMENT: _____

_____

_____

_____

_____

Name of Physician _____ Signature _____ Date _____