Applicant Name _____
(Last, First, Middle Initial)

Date of Birth_____/_____ /_____
(Month/Day/Year)

Reactive Tuberculin Test Evaluation Form
OMB No.: 0420-0550
Expiration Date: 00/00/0000

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. 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 service 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 or failure to disclose relevant information may 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 U.S.C. 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, licensed clinical social worker 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 and 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 complete from to this address.

I. Current TB test

Test must be within the past six months (tuberculin skin test or QuantiFeron-TB Gold). No test is required if there is documentation of the size of induration and documentation of previous treatment for latent TB.

Select one

Date: _____

☐ Tuberculin skin test

mm of induration: _____

☐ Interferon gamma releasing assay (QuantiFERON® -TB Gold/T. Spot Blood Test)

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 documentation required

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

- Applicants with a reported induration of ≥ 15mm (regardless of BCG Vaccination history) or interval change >10mm from previous skin test.
- Applicants with a history of a **prior or current** reactive tuberculin test with current symptoms (see V)

☐ Copy of baseline liver functions tests is required for:

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

IV. Risk assessment for developing active TB (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 homeless shelter)
☐	☐	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

V. 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

VI. Treatment

Note: In general, treatment of latent tuberculosis infection (LTBI) is highly recommended, in accordance with Centers for Disease Control and Prevention guidelines, 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. 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: _____

Date treatment completed: _____

☐ Full-course of alternative treatment:

Drug regimen: _____ Date treatment initiated: _____

Date treatment completed: _____

☐ Full-course or treatment not received nor recommended:

Please explain: _____

_____

_____

_____

_____

VII. Recommendations for further evaluation and treatment

_____

_____

_____

_____

Closing Signatures

Provider Signature/Title_____

Provider Name (Print) _____ Date _____

Provider License Number/State _____

Provider Address and Phone Number_____

_____

If evaluation completed by other than MD, DO, or NP licensed to practice independently, must be signed or co-signed by a licensed MD or DO.

Co-signature, if required in your state _____

License Number _____