OMB APPROVAL NO 1405-XXXX
EXPIRATION DATE: XX-XX-20XX
ESTIMATED BURDEN: XX MINUTES

U.S. Department of State
Bureau of Medical Services

TUBERCULOSIS (TB) RISK ASSESSMENT FOR LOCALLY EMPLOYED STAFF (LES)

Section I: Demographic and Employment Information - To be completed by the candidate/employee

Name *(Last, First, MI)*	Date of Birth (*mm-dd-yyyy*)
Date (*mm-dd-yyyy*)	Type of Evaluation (Note: Periodic Risk Assessment should focus on change in risk from previous assessment) ☐ Initial ☐ Periodic (*Drivers Only*)
Job Title/Section	Office/Location
Country of Residence	Country of Birth
Previous Anti-Tuberculosis ("BCG") Vaccine? ☐ Yes ☐ No	If yes, approximately when last received (mm-yyyy)

Section II: TB Risk Factors - To be completed by the candidate/employee

☐ Yes ☐ No	Do you have cough, fever, night sweats, loss of appetite, weight loss, or fatigue?	If yes, for how long and which symptoms?	
☐ Yes ☐ No	Have you ever had a positive tuberculosis (TB) skin test or blood test for TB?	If yes, When (*mm-dd-yyyy*)?	If yes, What type of test?
☐ Yes ☐ No	Have you ever been told you had or have latent tuberculosis Infection (LTBI)?	If yes, When (*mm-dd-yyyy*)?	Treated? ☐ Yes ☐ No
☐ Yes ☐ No	Have you ever been told you had or have TB disease, or have you ever been treated for active TB?	If yes, When (*mm-dd-yyyy*)?	Treated? ☐ Yes ☐ No
☐ Yes ☐ No	Have you ever been told you had or have an abnormal chest x-ray?	If yes, When (*mm-dd-yyyy*)?	
☐ Yes ☐ No	Have you lived in or traveled in a country identified by the WHO with increased TB risk (<u>greater than 50 per 100,000 incidence</u>*) for more than one month in the last three years?	If yes, what country/countries?	
☐ Yes ☐ No	In the last year, have you lived with, or spent time with someone with active TB?		
☐ Yes ☐ No	In the last year, have you closely interacted (more than 6 hours of face-to-face interaction at less than 6 feet (~2 meters) of distance) with high-risk populations (homeless, imprisoned, IV drug users, refugees, etc.)?	If yes, When (*mm-dd-yyyy*)?	
☐ Yes ☐ No	Do you have an immunocompromising condition, such as: • Diabetes • Chronic kidney failure • Cancer of the neck, head, lungs, blood, or lymph system • HIV/AIDS; or other condition affecting your immune system (including organ transplantation)		

Additional Comments?

Name of Examinee	DOB

Section III: Provider/Clinician Assessment of TB Risk

RISK ASSESSMENT - Check boxes as appropriate

Increased Risk (answering "yes" to one or more responses in Section II above)

☐ *Baseline chest x-ray required for new employees based on risk assessment (costs of the initial chest x-ray and IGRA or TST if indicated are covered as part of the pre-employment process)*

☐ **CHEST X-RAY POSITIVE** - Candidate/employee should seek follow-up care as indicated. Such care may include completion of TB risk assessment with Interferon-Gamma Release Assay (IGRA) (preferred), or Tuberculin Skin Test (TST) performed through the contracted local provider or the local health system. To continue candidacy or employment, candidate/employee is responsible for obtaining documentation certifying NO ACTIVE TB including completion of appropriate treatment. Costs for diagnostic tests beyond CXR and IGRA/TST, as well as treatment, are the responsibility of the candidate/employee.

☐ **CHEST X-RAY NEGATIVE** - Candidate/employee permitted to continue candidacy/employment. Candidate/employee may choose to undergo IGRA or TST through the contracted local provider. If they choose to undergo further testing and it is available, cost for IGRA and TST testing may be covered by the Mission as a courtesy. Any subsequent testing, costs, or treatments are the responsibility of the candidate/employee. A positive IGRA or TST in the absence of chest x-ray findings suggests latent tuberculosis infection (LTBI). Those with LTBI may continue their candidacy/employment and are encouraged to seek care per local public health recommendations. Treatment for LTBI is not required for candidacy/employment.

☐ **Low risk** (answering "no" to all responses in Section II above). Baseline chest x-ray/IGRA/TST not required.

Note: For driver/vehicle operators, the TB Risk Assessment Questionnaire should be repeated at the time of their periodic driver evaluation. Based on the Risk Assessment, actions should be taken as indicated above.

CHECK ONE OF THE FOLLOWING

☐ The above employee has no evidence of active TB based on the risk assessment or testing above.

☐ Further evaluation or testing required due to: _____

Provider/Clinician Name	Provider/Clinician Signature	Date (*mm-dd-yyyy*)

Countries with TB incidence greater than 50/100,000 are considered increased risk. For the most recent data on TB incidence, refer to the World Health Organization:
https://www.who.int/data/gho/data/indicators/indicator-details/gho/incidence-of-tuberculosis-(per-100-000-population-per-year)

Paperwork Reduction Act Statement

Releases or disclosures of confidential medical information are governed by the Privacy Act of 1974, as amended, 5 U.S.C. § 552a et seq., and the Rehabilitation Act of 1973, as amended, 29 U.S.C. § 701 et seq.

Privacy Act Statement

AUTHORITIES: The information is sought pursuant to the Foreign Service Act of 1980, as amended (Title 22 U.S.C. 4084, 3901, and 3984) and the Public Health Service Act of 1944, as amended (Title 42 U.S.C 247b-6).

PURPOSE: The information requested on this form is intended to prevent the introduction, transmission or spread of tuberculosis.

ROUTINE USES: Unless otherwise protected by law, the information solicited on this form may be made available to appropriate agencies, whether Federal, state, local, or foreign, for law enforcement and other authorized purposes. The information may also be disclosed pursuant to court order. The information may also be made available to local Health Units. More information on the Routine Uses for the system can be found in the System of Records Notice State-24, Medical Records.

DISCLOSURE: Providing this information is voluntary; however, failure to provide this information may result in disqualification of employment.

The Genetic Information Nondiscrimination Act of 2008 (GINA)

To the individual and/or health care provider completing the medical history review /exam: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you NOT provide any genetic information when responding to this request for medical information. 'Genetic Information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family members' genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.