



**Part I: Tuberculosis (TB) Screening Questionnaire (to be completed by incoming students)**

Name (First, Middle and Last): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address Line 1: \_\_\_\_\_

Address Line 2: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Date of Entry (MM/YYYY): \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ MSM ID#: \_\_\_\_\_

Phone Number: (\_\_\_\_\_) \_\_\_\_\_

Email address (MSM email only): \_\_\_\_\_

Program (circle one):      MPH                  MSBR                  MSNS                  MSCR                  PhD

**Note: This form is intended for students who are not in clinical programs such as MD, PA or MSMS. If you are in the MD, PA, or MSMS program, do not utilize this form for TB screening. For any questions or concerns call Student Health and Wellness Center at: (404) 756-1241.**

**Mail completed forms to:  
Student Health and Wellness Center  
ATTN: Immunization Records <Insert Program Name Here>  
455 Lee Street SW, Suite 300A  
Atlanta, GA 30310**

Please answer the following questions:

Have you ever had close contact with persons known or suspected to have active TB disease?      Yes                  No

Were you born in one of the countries or territories of the World Bank?

Tuberculosis Screening Form

*Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2020. Countries with incidence rates of ≥ 20 cases per 100,000 population.*

Have you had frequent or prolonged visits\* to one or more of the countries or territories listed above



**\*\*Interpretation guidelines:**

>5 mm is positive:

Recent close contacts of an individual with infectious TB

persons with ~~www.fda.gov/cdrh/oc/ohrt/ohrt0304081(v.0)tdr.0746701217~~