QUEENSBOROUGH COMMUNITY COLLEGE | CUNY

Office of Health Services
Medical Arts Building, Room, MC-02
222-05 56th Avenue, Bayside, New York 11364-1497
Telephone (718) 631-6375 • Fax (718) 631-6330

Tuberculosis Screening for Massage Therapy

Please submit **Two** copies and original of all material to Health Services. Health Services will **Not** make copies for you. Whiteout renders forms null and void.

– To be completed by Health Practitioner (MD, DO, NP, or PA) –

Student Information (Please print):

CUNYFIRST ID No.: _____ Last four digits of S.S. No.: _____

Last Name: _____ First Name: _____ Birth Date: _____ /_____ /_____

Gender: Male _____ Female _____ Trans. (specify) _____ Other (specify) _____

QuantiFERON-TB Gold *(lab report required)*

- Chest x-ray report required only for **positive** QuantiFERON-TB Gold

OR

TST Step 1 Implant Date: _____ /_____ /_____ Read Date: _____ /_____ /_____ Result: _____ mm

TST Step 2 Implant Date: _____ /_____ /_____ Read Date: _____ /_____ /_____ Result: _____ mm

Note: All students with a history of positive TST or positive QFTB-Gold, including those who have previously received BCG vaccination, are required to submit a chest x-ray (CXR) report to the Office of Health Services. Students who recently converted to positive TST or positive QFTB-Gold should be offered prophylactic treatment unless medically contraindicated to receive treatment. Student refusal of prophylactic treatment for LTBI must be indicated below.

Reason: _____

Latent Tuberculosis Infection (LTBI) Treatment Start Date: _____ /_____ /_____ End Date: _____ /_____ /_____

Health Practitioner Name: _____ Title: _____ License No.: _____

Address: _____ City _____ State _____ Zip _____

Office Phone No.: _____-_____-_____ Fax No.: _____-_____-_____

Examination Date: _____ /_____ /_____

Health Practitioner Signature _____

Health Practitioner Stamp Required (MD, DO, NP, or PA)

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