LOS ANGELES UNIFIED SCHOOL DISTRICT
HUMAN RESOURCES DIVISION – EMPLOYEE HEALTH SERVICES
Tuberculosis Compliance Program
333 S. Beaudry Ave., 14th Floor, Los Angeles, CA 90017
Phone: (213) 241-6326 Fax: (213) 241-8918 E-mail: employeehealth@lausd.net

Tuberculosis Test Results

Effective January 1, 2015, an Adult TB Risk Assessment is the primary tool used for Tuberculosis screening for applicants. employees, and volunteers. For individuals who still wish to submit current results from Tuberculin Skin (PPD) or Blood (IGRA) Tests, this form may be used. A chest X-Ray is acceptable only if the PPD or blood test is, or has ever been, positive.

APPLICANTS NOTE Risk Assessments, blood or skin tests must be done within 60 days prior to the date of employment. Chest X-rays must have been done within 6 months prior to the date hire and only if there is a history of a previous positive skin or blood test. The preferred form for documenting the results of the Adult TB Risk Assessment only is the *Certificate of Completion, Form 8478.*

IMPORTANT NOTES FOR APPLICANTS AND CURRENT EMPLOYEES:

1. **We will not accept incomplete/invalid documentation. Make sure your documentation has the required information to include your name and employee number or social security number and medical office stamp.**
2. Current employees only may submit evidence of a negative TB skin, blood test or chest X-Ray performed within the last three years. (Chest x-ray results will not be accepted without proof of previous positive skin or blood test)
3. Tests shall not be performed on work time. Use illness time as you would for any medical appointment.

SUBMIT RESULTS VIA:

Fax or e-mail: Fax: (213) 241-8918 E-mail: employeehealth@lausd.net

In person: LAUSD; Employee Health Services – TB Compliance Program; 333 S. Beaudry Avenue, 14-110 Los Angeles, CA 90017

U.S. Mail: LAUSD; Employee Health Services; TB Compliance; P.O. Box 513307-1307: Los Angeles, CA 90051

Employee #: _____	**Name:** _____	**Phone:** _____
MANTOUX SKIN TEST **(Tine skin test unacceptable.)** Test Date: _____/_____/_____ Placed by _____ Date Read _____/_____/_____ Read By _____ **RESULT (REQUIRED)** Induration _____ Millimeters (>9mm is positive) **MEDICAL OFFICE STAMP (REQUIRED):** **Name** _____ **Address** _____ _____ **Phone:** _____	**QUANTIFERON/ IGRA** Collection Date _____/_____/_____ By _____ **RESULT (REQUIRED)** Interpretation _____ **MEDICAL OFFICE STAMP (REQUIRED):** **Name** _____ **Address** _____ _____ **Phone** _____	**CHEST X-RAY** Date X-ray Taken _____/_____/_____ Impression (Not Prelim.)_____ _____ **MD or DO ONLY** MD or DO Name _____ MD or DO License # _____ MD or DO Signature_____ **MEDICAL OFFICE STAMP (REQUIRED):** **Name** _____ **Address** _____ _____ **Phone** _____

To confirm if your form has been received, please e-mail **employeehealth@lausd.net**, Subject: TB Notice/ (your employee #).

*****Keep a copy for your records*****