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All volunteers at Seattle Children's must be screened for tuberculosis and provide acceptable verification of the TB screening before starting their volunteer service.

**We ask you to use only the ATTACHED FORM** to submit all of your required information. We cannot accept copies of your personal health records, which may contain other personal health information, your personal medical record number and/or social security number. Using only **THIS FORM** will ensure that we have all the information we require in the correct format. Submitting information in another format may cause delay in starting your volunteer service.

**Anything not signed by an official health care provider or their representative will not be accepted unless verified as an approved electronic download.**

*Please note: The next page of this document can be given to your Health Care Provider if there are any questions as to why we require **two** separate PPD skin tests.*

**We will not schedule your training or first day of service until these requirements have been met. Once we receive your documentation and it is approved, we will contact you to set up next steps.**

Any questions can be directed to Volunteer Services: **(206) 987-4655**.

**Thank you!**

TO: Health Care Provider

RE: Tuberculosis Screening Requirements for Volunteering at Seattle Children's Hospital

All **volunteers** must be screened for tuberculosis (TB) prior to starting their volunteer service at Seattle Children's Hospital.

Washington State Department of Health and the Department of Occupational Safety and Health require that Seattle Children's TB screening program is in accordance with the Centers for Disease Control and Prevention MMWR *Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Settings*, Volume 54/RR-17; December 2005. This includes meeting the documentation requirements as outlined below.

**Screening requirements may be met by one the following screening options:**

- **A two-step tuberculosis skin test (TST). This is a complete set of TWO tests with read in number of millimeters of induration, given a minimum of one week apart.**

- OR -

- **A blood assay for mycobacterium tuberculosis (BAMT), also known as Quantiferon gold blood test, with documentation of negative test result.**

- OR -

- **Documentation of a past positive TB screening test. The documentation must include report of a positive skin test including number of millimeters of induration or positive BAMT, a report of a normal chest x-ray that was done to rule out active pulmonary TB, and documentation of treatment for latent TB infection, if possible.**

If you have any questions regarding these requirements please feel free to contact our Occupational Health Services Department. The phone number is 206-987-3392 or you may email [OHS@seattlechildrens.org](mailto:OHS@seattlechildrens.org).



Name: \_\_\_\_\_

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

(please print clearly)

Phone: \_\_\_\_\_

**To be completed by the Health Care Provider who can verify Tuberculosis screening documentation:**

### Tuberculosis (TB) Screening - TB Test via PPD – Skin Test

Please note: Two (2) complete skin tests are required if you have not had a previous test. Each completed test must have a Health Care Providers Signature.

#### Test #1

Date Placed: \_\_\_/\_\_\_/\_\_\_ Date Read: \_\_\_/\_\_\_/\_\_\_ Induration: \_\_\_\_\_ mm

Positive

Negative

\_\_\_\_\_  
**Health Care Provider Signature - Test #1**

\_\_\_/\_\_\_/\_\_\_  
Date

Printed Name: \_\_\_\_\_

Health Care Institution: \_\_\_\_\_

Address: \_\_\_\_\_

Contact phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_

#### Test #2

Date Placed: \_\_\_/\_\_\_/\_\_\_ Date Read: \_\_\_/\_\_\_/\_\_\_ Induration: \_\_\_\_\_ mm

Positive

Negative

\_\_\_\_\_  
**Health Care Provider Signature - Test #2**

\_\_\_/\_\_\_/\_\_\_  
Date

Printed Name: \_\_\_\_\_

Health Care Institution: \_\_\_\_\_

Address: \_\_\_\_\_

Contact phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_

## Tuberculosis (TB) Screening - TB Test via Quantiferon Gold Blood Test

Date: \_\_\_/\_\_\_/\_\_\_

Positive

Negative

\_\_\_\_\_  
*Health Care Provider Signature*

\_\_\_/\_\_\_/\_\_\_  
Date

Printed Name: \_\_\_\_\_

Health Care Institution: \_\_\_\_\_

Address: \_\_\_\_\_

Contact phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_

### History of Positive TB Screening Test

Requires documentation confirming a previous positive tuberculin skin test in section above, documentation of a normal chest x-ray and antibiotic treatment following. A Seattle Children's Tuberculosis Symptom Surveillance form is also required initially and annually. Form is available in the volunteer office.

Date of positive TB test: \_\_\_/\_\_\_/\_\_\_ Induration: \_\_\_\_\_ mm

Date of chest X-ray: \_\_\_/\_\_\_/\_\_\_

Result:  Positive for TB

Negative for TB

\_\_\_\_\_  
*Health Care Provider Signature*

\_\_\_/\_\_\_/\_\_\_  
Date

Printed Name: \_\_\_\_\_

Health Care Institution: \_\_\_\_\_

Address: \_\_\_\_\_

Contact phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_