PORTERVILLE COLLEGE
HEALTH CAREERS
TUBERCULOSIS EXAMINATION

Student’s Name: ____________________________
(please print)

Indicate Program:
__ Registered Nursing
__ Vocational Nursing
__ Psychiatric Technician

Date of Intradermal Tuberculin Test #1: ________________
NEG: ____ POS: ____

Authorized Signature: ________________________
Date: ________________________

Name of Healthcare Provider: ________________________
CA License Number: ________________________

Date of Intradermal Tuberculin Test #2: ________________
NEG: ____ POS: ____

Authorized Signature: ________________________
Date: ________________________

Name of Healthcare Provider: ________________________
CA License Number: ________________________

OR

Date of Chest X-Ray: ________________
Results: ________________
(within past 2 years)

Authorized Signature: ________________________
Date: ________________________

Name of Healthcare Provider: ________________________
CA License Number: ________________________

NOTE: 2 TB skin tests required