Tri-City Medical Center
EMPLOYEE HEALTH SERVICES
4002 Vista Way • Oceanside • CA • 92056
T) 760.940.7270 • F) 760.940.4005 • Mon.-Fri. 7:30am-4:00pm

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TUBERCULOSIS (TB) CONVERTORS FORM

Name: _____ Date: _____

Employer: Tri-City Medical Center Date of Birth: _____

Job Title: _____ I.D. Number: _____

Please check appropriate box:

New Hire: ❑ Annual Review: ❑ Volunteer: ❑ TCMC Auxiliary: ❑ TCMC Jr. Volunteer: ❑

Do you have any of the following?:

A history of a positive Tuberculin skin test:	YES____ NO____
Pain in your chest:	YES____ NO____
A cough lasting 3 weeks or longer:	YES____ NO____
Blood-streaked sputum:	YES____ NO____
Fatigue for 2 weeks or more:	YES____ NO____
Night sweats:	YES____ NO____
Decreased appetite:	YES____ NO____
Unexplained weight loss unrelated to dieting:	YES____ NO____
Fever and chills for more than one week:	YES____ NO____

Signature: _____

Employee Health Services Use Only

Chest X-ray Referral Date: _____ Chest X-ray Completed: _____

Chest X-ray Results: _____

Comments: _____

_____

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