# TB Document F: State of Hawaii TB Clearance Form

Hawaii State Department of Health
Tuberculosis Control Program

| Patient Name | DOB | TB Screening Date |
|---|---|---|
| | | |

I have evaluated the individual named above using the process set out in the DOH TB Clearance Manual dated 2/10/17 and determined that the individual does not have TB disease as defined in section 11-164.2-2, Hawaii Administrative Rules.

| Screening for schools, child care facilities or food handlers *(TB Document A or E)* |
|---|
| ☐ Negative TB risk assessment |
| ☐ Negative test for TB infection |
| ☐ Positive test for TB infection, and negative chest X-ray |

| Initial Screening for health care facilities or residential care settings (*TB Document B or C)* |
|---|
| ☐ Negative test for TB infection (2-step) |
| ☐ New positive test for TB infection, and negative chest X-ray |
| ☐ Previous positive test for TB infection, negative CXR within previous 12 months, and negative symptom screen |
| ☐ Previous positive test for TB infection, and negative CXR |

| Annual Screening for Health care facilities or residential care settings (*TB Document D)* |
|---|
| ☐ Negative test for TB infection |
| ☐ New positive test for TB infection, and negative chest X-ray |
| ☐ Previous positive test for TB infection, and negative symptoms screen |
| ☐ Previous positive test for TB infection, and negative CXR |

Signature or Unique Stamp of Practitioner: _____

Printed Name of Practitioner: _____

Healthcare Facility: _____

This TB clearance provides a reasonable assurance that the individual listed on this form was free from tuberculosis disease at the time of the exam. This form does not imply any guarantee or protection from future tuberculosis risk for the individual listed.