

Network Staffing Resources

TB CONVERTER – ANNUAL EMPLOYEE HEALTH

Name: _____

CURRENT ASSESSMENT:

- | | | |
|--|-----|----|
| 1. Any unexplained fever in recent weeks to months? | Yes | No |
| 2. Any unexplained persistent cough for over 3 weeks? | Yes | No |
| 3. Any coughing up blood, yellow or green sputum? | Yes | No |
| 4. Any drenching night sweats in recent months? | Yes | No |
| 5. Any unexplained weight loss in recent months? | Yes | No |
| 6. Any unexplained loss of appetite in recent months? | Yes | No |
| 7. Have you been evaluated for pulmonary symptoms suggestive of TB in the last year? | Yes | No |

If yes, please comment: _____

**After completing, please return this form to
Liz Herrell no later than**

Signature

Date

Social Security Number