



Part I: Tuberculosis (TB) Screening Questionnaire (to be completed by incoming students)

Name (First, Middle and Last): _____

Date of Birth: _____

Address Line 1: _____

Address Line 2: _____

City, State, Zip Code: _____

Date of Entry (MM/YYYY): _____/_____/_____ MSM ID#: _____

Phone Number: (_____) _____

Email address (MSM email only): _____

Program (circle one): MPH MSBR MSNS MSCR PhD

Note: This form is intended for students who are not in clinical programs such as MD, PA or MSMS. If you are in the MD, PA, or MSMS program, do not utilize this form for TB screening. For any questions or concerns call Student Health and Wellness Center at: (404) 756-1241.

**Mail completed forms to:
Student Health and Wellness Center
ATTN: Immunization Records <Insert Program Name Here>
455 Lee Street SW, Suite 300A
Atlanta, GA 30310**

Please answer the following questions:

Have you ever had close contact with persons known or suspected to have active TB disease? Yes No

Were you born in one of the countries or territories of the World Bank?

Tuberculosis Screening Form

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2020. Countries with incidence rates of ≥ 20 cases per 100,000 population.

Have you had frequent or prolonged visits* to one or more of the countries or territories listed above

