Certificate of Clearance
Tuberculosis Risk Assessment and/or Examination

This certificate satisfies **job-related requirements** in the California Education Code, Sections 49406 and 8708.6 and the California Health and Safety Code, Section 1597.055, 121545 and 121555 for TB clearance. This certificate of clearance can also be provided to patients as documentation that satisfies TB screening requirements for other groups, such as students, K-12 as well as those screened through their primary healthcare provider.

Patient First and Last Name:

_____

Date of birth (MM/DD/YYYY): _____

The above named patient has submitted to a tuberculosis risk assessment. The patient does not have risk factors, or if tuberculosis risk factors were identified, the patient has been examined and determined to be free of infectious tuberculosis.

Date of assessment and/or examination (MM/DD/YYYY) _____

X _____
Signature of Health Care Provider completing the risk assessment and/or examination

Health Care Provider printed Name*:

_____

Health Care Provider Address:

_____
(include Number, Street, City, State, and Zip Code):

*May use label or clinic stamp:

Adapted for LAC use from the California School Staff and Volunteer TB Risk Assessment available on the PROVIDERS page at www.ctca.org

CDPH California Department of PublicHealth

CTCA California Tuberculosis Controllers Association

Curry International Tuberculosis Center

County of Los Angeles Public Health

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