Gaunley Home Care, LLC
720 Prospect Avenue
Scranton, Pennsylvania, 18505
Phone: 267-515-9723
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Tuberculosis Screening Report

Employee name: _____ **Date:** _____

Test for tuberculosis (TB) shall be conducted based on the guidelines provided by Centers for Disease Control and Prevention (CDC).

Note: If you are currently screened from another agency then you are not required to be screened again. The current screening documents may not be more than 12 months prior to the employment start date. All DCWs are subject to the annual screening after the first screened date.

Date Taken: _____ Read date: _____

Result

□Negative Size of induration: _____

□Positive Size of induration: _____

Doctor's/Nurse's Signature: _____ Date: _____

License Number (if applicable): _____

Clinic/Hospital Name: _____

Clinic/Hospital Address: _____ City: _____ State: _____

X-ray report

Date Taken: _____ Read date: _____

Chest X-ray Result

□Negative

□Positive □Active: □Inactive:

Doctor's/Nurse's Signature: _____ Date: _____

Description if any constraints: