



TWO-STEP TUBERCULIN SKIN TEST (TST)

Last name:		First name:		
Date of birth (yyyy/mm/dd):		Telephone:		
Email:		Year of admission:	Student number:	
Program	Nursing <input type="checkbox"/> Generic program (select campus): <input type="checkbox"/> Ottawa <input type="checkbox"/> Woodroffe <input type="checkbox"/> Pembroke <input type="checkbox"/> Bridging <input type="checkbox"/> Second Entry <input type="checkbox"/> Graduate MScN <input type="checkbox"/> Diploma in PHCNP	Rehabilitation Sciences <input type="checkbox"/> Audiology <input type="checkbox"/> Speech Language Pathology <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Physiotherapy	Food and Nutrition Sciences <input type="checkbox"/>	Human Kinetics <input type="checkbox"/>
	Tuberculin Skin Test			
Step 1:				
Date administered (yyyy/mm/dd):		Time: _____ : _____ <input type="checkbox"/> AM <input type="checkbox"/> PM		
Results must be read within 48 to 72 hours of administration				
Date read (yyyy/mm/dd):		Time: _____ : _____ <input type="checkbox"/> AM <input type="checkbox"/> PM		
Results: _____ mm of induration				
Step 2: Min. 7 days after administration of step 1. Max. 28 days (in some cases, up to 12 months is acceptable).				
Date administered (yyyy/mm/dd):		Time: _____ : _____ <input type="checkbox"/> AM <input type="checkbox"/> PM		
Results must be read within 48 to 72 hours of administration				
Date read (yyyy/mm/dd):		Time: _____ : _____ <input type="checkbox"/> AM <input type="checkbox"/> PM		
Results: _____ mm of induration				
If induration \geq 10mm, a chest x-ray is required:				
Date of CXR (yyyy/mm/dd):		Results: _____		
Attach a copy of CXR report				
Signature of attesting health care professional (HCP)				
Name:		Initials:		Medical clinic stamp:
Address:				
Tel.:		Profession:		
Signature:		Date:		

Email this form to your student placement and experiential learning requirements management adviser at the Faculty of Health Sciences.