# MANTOUX Tuberculosis Skin Test (PPD)

**ACCESS Employee Name:**_______________________________________________
**(Last) (First)**

**SSN:** ______________________ **Title:** _________ **DOB:** _________________________

**Signature:** ____________________________________________ ____________________
**Access Nursing Employee Date**

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**Testing Facility Name & Location:**____________________________________________

**Date Placed:** _______________ **Site:** ____**Left Forearm** ____ **Right Forearm**

**Lot Number:** ____________________ **Exp Date:** ____________________

**Administered By (Print):**_______________________________ **( MD NP RN LPN)**

**Signature of Nurse Administering:** _____________________________________________

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**Date Read (within 48-72 hours from date placed):** _______________

**Induration (mm must be noted):** ________________

**PPD Mantoux Test Results:** ☐ **Negative** ☐ **Positive**

**Read By (Print):**_____________________________________ **( MD NP RN LPN)**

**Signature of Reading Nurse:** _______________________________________________

**NOTE: In order for this form to be valid and acceptable, all sections must be completed and the facility stamp must be placed in the box to the right. If any sections are left blank or incomplete, this form will be denied.**

| Place Facility Stamp Here |
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**If you have any questions, please reach out to us:**
**New York – (212) 286-9400**
**New Jersey – (201) 217-0707**