

SPRINGDALE FIRE DEPARTMENT

Annual TB Surveillance Form

Member Name: _____ Date: _____

Rank: _____ Station Assignment: _____

Since records indicate that you have previously tested positive to PPD skin testing, the following questions must be answered each year as part of our annual TB testing program. Please return this completed form to the designated Infection Control Officer.

During the past year, have you experienced or are you experiencing any of the following signs or symptoms? Please circle one.

Persistent and/or productive cough.	Yes	No
Night sweats.	Yes	No
Unexplained fevers.	Yes	No
Weight loss (unrelated to dieting).	Yes	No
Chronic weakness or fatigue.	Yes	No
Coughing up blood.	Yes	No

Member Signature

Date