Student Tuberculosis (TB) Evaluation Form

The National Institute for Medical Assistant Advancement (NIMAA) requires that I receive initial tuberculosis screening prior to starting school.

You have my permission to send NIMAA information regarding this matter. The address to which this information can be sent is:

The National Institute for Medical Assistant Advancement 1525 Raleigh St., Ste. 260, Denver, CO 80204

1525 Raieign St., Ste. 260, Denver, CO 80204		
Signature of StudentName of Student		
Name of Student		
NIMAA requires a PPD test for all students of	r BAMT	
Date of PPD plant Date	Read Indurationmm	
OR BAMT testing (QuantiFERON or T-Sp	ot blood test) Date: Result:	<u> </u>
After considering medications and diagnose	s does your patient screen: Positive or Negative]
If patient screened positive for tuberculo	Diagnosis: Active TB Latent TB Date medication started:	
Address: Phone Number:	Attach provider stamp belo	<u>iw</u>
<u>History of Positive Testing</u>		
 Has your patient had a positive tubercul the past? YES □ NO □ 	osis skin test (TST) or blood assay for <i>M.tuberculosis</i> (BAM	IT) in
2. Was the patient treated with medication for	either Active TB or Latent TB? YES D NO D	
	ient and have determined that they are free of any communica	ıble
Name of Provider: Specialty: Address: Phone Number: Signature:	Attach provider stamp belo	<u>.w</u>