LIBERTY HEALTHCARE CORPORATION AND AFFILIATES (LIBERTY) TUBERCULOSIS SCREENING WAIVER FORM

Employee/Subcontractor Name: _____

(Please Print Clearly)

Today's Date: _____ **Date of Last Chest X-Ray:** _____ **N/A** ☐ **Unknown** ☐

Please indicate if you are having ANY of the following problems for three (3) weeks OR longer from today's date:

1.	**Chronic Cough**	**YES:** ☐	**NO:** ☐
2.	**Production of Sputum:**	**YES:** ☐	**NO:** ☐
3.	**Blood-Streaked Sputum:**	**YES:** ☐	**NO:** ☐
4.	**Unexplained Weight Loss:**	**YES:** ☐	**NO:** ☐
5.	**Fever:**	**YES:** ☐	**NO:** ☐
6.	**Fatigue/Tiredness**	**YES:** ☐	**NO:** ☐
7.	**Night Sweats:**	**YES:** ☐	**NO:** ☐
8.	**Shortness of Breath**	**YES:** ☐	**NO:** ☐

To my knowledge, I don't know of any or have any evidence of the symptoms listed above.

_____ _____

Liberty employed or subcontracted staff signature **Date**

To my knowledge, this patient does not have any evidence of Pulmonary Tuberculosis or Contagium:

_____ _____

Health Care Provider (MD, DO, NP) Signature **Date**