Family & Community Medicine
UNIVERSITY OF TORONTO

TB Test Form

Submission of this form is mandatory if the results of last year's TB test was negative. No further testing is required if your TB test result from the previous academic year was positive.

Deadline: Please submit the completed form online, using ShareFile, by **August 4, 2017**.
Upload to this ShareFile folder: https://utmed.sharefile.com/r/06599406d3f04a9e
Save your file as: "Class – LastName, FirstName – TB – 2017" (e.g. PA2019 – Smith, Mary – TB – 2017)

Notice of Collection

The University of Toronto respects your privacy. The personal information provided on this form will be used by the administrative and student service offices at the Faculty of Medicine to administer your enrolment and program-related activities in the University of Toronto Doctor of Medicine Program.

The personal information provided on this form will only be used and protected in accordance with the Freedom of Information and Protection of Privacy Act. If you have any questions about this policy and/or ShareFile, please contact Janet Hunter, Director of Enrolment Services & Faculty Registrar, at 1 King's College Circle, Toronto, Ontario, M5S 1A8 or registrar.medicine@utoronto.ca.

SECTION 1 - STUDENT INFORMATION

Student Number:	**Year of Study:**
Last Name:	**First Name:**

SECTION 2 - TUBERCULIN TEST

Test Date (mm/dd/yyyy): _____	Results: Negative ☐ Positive ☐*	Reading (mm of Redness & Induration): _____
Date of last known negative (mm/dd/yyyy): _____	Previous BCG vaccination: Yes No Previous Treatment for TB: Yes No	Date of BGD (mm/dd/yyyy): _____

***If test results are positive, a chest x-ray will be required. All students who test positive must contact the Office of Health Professions Student Affairs (OHPSA) at** ohpsa.admin@utoronto.ca

CHEST X-RAY:

X-Ray Date (mm/dd/yyyy): _____ Results: _____ (Normal/Abnormal)

SECTION 3 - TRAINEE AUTHORIZATION

I give my consent that the information on this form may be shared with university/hospital teaching and administrative staff in appropriate cases.

Signature of student: _____ **Date (mm/dd/yyyy):** _____

SECTION 4 - CLINIC/HEALTH CENTRE AUTHORIZATION

I certify that the above information is complete and accurate:

_____

(name, address, and phone number of clinic/health care centre/hospital where the form was completed)

Signature of health care professional: _____ **Date (mm/dd/yyyy):** _____
(trainee cannot sign own form)