

**LOS ANGELES UNIFIED SCHOOL DISTRICT**  
**HUMAN RESOURCES DIVISION – EMPLOYEE HEALTH SERVICES UNIT**  
**Tuberculosis Compliance Program**  
**333 S. Beaudry Ave., 14<sup>th</sup> Floor, Los Angeles, CA 90017**  
Phone: (213) 241-6326 Fax: (213) 241-8918 E-mail: [employeehealth@lausd.net](mailto:employeehealth@lausd.net)

**Tuberculosis Test Result Form**  
(For Permanent LAUSD Employees)

**You can have the test performed by:**

- **Your personal health care provider**
- **Your local county health department (uninsured employees only)**  
For L.A. County residents, visit [publichealth.lacounty.gov/tb/skintest.htm](http://publichealth.lacounty.gov/tb/skintest.htm) for a list of clinics and community health centers.
- **Employee Health Services (Beaudry Bldg.) no longer provide Mantoux skin tests or chest x-rays**

**IMPORTANT NOTES – READ CAREFULLY:**

1. You may submit evidence of a negative Mantoux skin test or chest x-ray performed within the last three years.
2. Chest x-rays are only used if (1) you’ve ever had a positive skin test and (2) a physician (**MD** or **DO** only) signs the result form.
3. We suggest you use the result form below. If you submit a different result form, it must include your employee number and all information required below for the specific test.
4. We will not accept incomplete/invalid documentation. Make sure your documentation has the required information.
5. Neither test shall be performed on work/duty time. If necessary, you may use illness time as you would for any medical related appointment.

Emp#:		
Phone:	Name:	
<b>MANTOUX SKIN TEST</b> (5 TU PPD required. Tine skin test unacceptable.)	<b>CHEST X-RAY</b>	
Test Date _____	Positive Skin Test Date (estimate) _____	
Placed By _____	Date X-ray Taken _____	
Date Read _____	Impression (Not Prelim.) _____	
Read By _____	Person is free of communicable TB: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Induration _____ Millimeters (>9mm is positive)	Physician’s Name _____	
<b>MEDICAL OFFICE CONTACT INFO:</b>	Physician’s Degree ( <u>must</u> be MD or DO) _____	
Name _____	Physician’s Signature _____	
Address _____	<b>MEDICAL OFFICE CONTACT INFO:</b>	
Phone _____	Name _____	
	Address _____	
	Phone _____	

<b>Submit Your Result Form Via:</b>	
<b>Fax:</b>	(213) 241-8918 Attn. TB Compliance
<b>E-mail:</b>	<a href="mailto:employeehealth@lausd.net">employeehealth@lausd.net</a> Subject: TB Compliance
<b>School Mail:</b>	Employee Health Services Attn. TB Compliance Beaudry Bldg., 14th Floor
<b>U.S. Mail:</b>	Employee Health Svcs (14th FL) Attn. TB Compliance P.O. Box 3307 Los Angeles, CA 90051
<b>To Confirm Compliance:</b>	
If you want to confirm our office received your result form, send an e-mail to:	
<a href="mailto:employeehealth@lausd.net">employeehealth@lausd.net</a>	
Subject: TB Confirmation - Emp# xxxxxx	

\*\*\* Keep a copy of your result form for your records \*\*\*

