STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS

WAIVER OF TUBERCULOSIS TESTING

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NAME (PRINT)

SOCIAL SECURITY NUMBER

DATE OF BIRTH

PROGRAM/AGENCY REPRESENTED

THIS IS TO CONFIRM THAT I **DO NOT** HAVE SYMPTOMS CONSISTENT WITH TUBERCULOSIS. PLEASE CHECK ANY OF THE FOLLOWING COMMON SYMPTOMS OF TUBERCULOSIS THAT YOU HAVE:

- ☐ night sweats (waking up from sleep drenched in sweat)
- ☐ unexplained fever (fever for several weeks, unrelated to a known illness)
- ☐ chronic cough lasting longer than three weeks
- ☐ coughing up blood
- ☐ loss of appetite/unexplained weight loss
- ☐ feeling tired all the time and/or being really weak

☐ I do ☐ do not have any of these symptoms

☐ I have ☐ have not had recent contact with someone with contagious tuberculosis.

To the best of my knowledge, I do not have contagious tuberculosis.

I understand the risk for tuberculosis exposure involved in accessing DOC facilities.

I hereby waive the TB testing provided by the DOC.

I am aware that this waiver of testing is effective for this visit at this facility only.

I am aware that I can waive TB testing five times per year before required to submit to TB testing.

SIGNATURE	DATE
STAFF WITNESS SIGNATURE	DATE

DISTRIBUTION: FAX TO EMPLOYEE HEALTH AND SAFETY AT (573) 526-2608