University Health Clinic
THE UNIVERSITY OF TEXAS AT TYLER
3310 Patriot Drive, Tyler, TX 75701

Mandatory Tuberculosis Screening Documentation Form

The University of Texas at Tyler requires all incoming international students and scholars who originate from countries that are considered to be at higher risk for tuberculosis (TB) disease (as defined by the U.S. Center for Disease Control and Prevention) to be screened for TB. This screening test can be completed either in one’s home country before traveling to Tyler, or in Tyler at the University Health Clinic at a cost of $110. Depending on your health insurance plan, this cost may or may not be covered. Only the following two types of Interferon-Gamma Release Assays (IGRAs) blood tests are accepted by UT Tyler for the purposes of TB screening:
- QuantiFERON ®-TB Gold In-Tube test (QFT-GIT)
- T-SPOT ®.TB test (T-Spot)

International students will be restricted from attending New International Student Orientation or from registering for or attending classes until this requirement is met.

Directions: Complete the information in Part I and II below. Take the form to your local clinic or to the UT Tyler University Health Clinic to complete your TB Screening during TB Clinic hours.

------------------------------------------ ALL INFORMATION MUST BE IN ENGLISH ------------------------------------------

Part I:

Applicant Name_________________________________________ Date of Birth_______ Male Female

Last First Middle (Month/Day/Year) (circle one)

Applicant Local Address_________________________________________________________

Applicant Email Address_________________________________ Applicant Phone Number ____________

Applicants ID Number_____________________________ Applicant Signature_____________________________________________________

I am a UT Tyler: ☐ Graduate or Undergraduate Student ☐ IELI Student

(Choose one) ☐ Exchange Visiting Scholar

Part II:

Please answer the following questions:

1. Have you ever had a positive tuberculin skin test in the past? ☐ Yes ☐ No

2. Have you ever had close contact with anyone who was sick with tuberculosis (TB)?
   ☐ Yes ☐ No

3. Were you born in one of the countries listed on the chart on page 2 of this form and arrived in the U.S. within the past 5 years? ☐ Yes ☐ No

4. Have you ever traveled to one of the countries listed in the chart on page 2 of this form?
   ☐ Yes ☐ No

If yes, please circle the country/countries.

NOTE: Any student submitting false or fraudulent information will be subject to disciplinary action.

The University of Texas at Tyler is an Equal Opportunity/Affirmative Action university.
Countries considered high burden for tuberculosis disease, as defined by the Centers for Disease Control and Prevention (CDC)

- Angola
- Bangladesh
- Brazil
- Cambodia
- Central African Republic
- China
- Congo
- Democratic People's Republic of Korea
- Democratic Republic of Congo
- Ethiopia
- India
- Indonesia
- Kenya
- Lesotho
- Liberia
- Mozambique
- Myanmar
- Namibia
- Nigeria
- Pakistan
- Papua New Guinea
- Philippines
- Russian Federation
- Sierra Leone
- South Africa
- Thailand
- Tanzania, United Republic of
- Viet Nam
- Zambia
- Zimbabwe

http://www.stoptb.org/countries/tbdata.asp

REQUIRED TESTING
Information to be completed by Licensed Medical Provider

IGRA Blood Test Result (QFT-GIT or T-Spot Only)

☐ Negative  ☐ Positive

TEST LAB REPORT MUST BE INCLUDED! DATE OF TEST (Month/Day/Year)

Printed Name of Licensed Medical Personnel ________________________________

Signature of Licensed Medical Personnel ________________________________

Name and Address of Provider or Clinic ________________________________

Phone Number_________________  Email ________________________________  Clinic/Facility Stamp

Chest X-ray required if:

Patient’s IGRA blood test is positive.

Chest X-ray Results:  ☐ Normal  ☐ Abnormal ________________________________ Date of X-Ray (Month/Day/Year)

Reading – results of X-ray: ________________________________________________

Signature of Radiologist or Ordering Physician: ________________________________

Name of Facility where X-ray was taken: ________________________________  Clinic/Facility Stamp

Address: ___________________________________________________________________

__________________________________________________________________________

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