



Family Works

5604 Medical Circle
Madison, Wisconsin 53719

TB Skin Test Documentation

Name: _____ DOB: _____

Date Given: _____

Location (please circle): Right Forearm
Left Forearm

Date Results Read: _____

Result: (# of Millimeters) _____

Health Care Provider: _____

Clinic/Office Name: _____

Address: _____

Phone: _____

Signature: _____ Date: _____