

**SCHOOL OF NURSING & DENTAL HYGIENE  
TB ANNUAL SELF-ASSESSMENT FORM**

The following individual has taken an initial chest x-ray for tuberculosis assessment for University of Hawaii School of Nursing & Dental Hygiene employment purposes. This self assessment is in place of an additional x-ray due to the recommendation by the State of Hawaii Department of Health that it may be harmful to the employee's health.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please complete.

Do you have any signs or symptoms of the following:

|                                   |     |    |
|-----------------------------------|-----|----|
| Cough lasting longer than 3 weeks | yes | no |
| Fever lasting longer than 3 weeks | yes | no |
| Night sweats                      | yes | no |
| Unintentional weight loss         | yes | no |
| Malaise/fatigue                   | yes | no |

If I have answered yes to two or more of the above symptoms I will check with my physician regarding my condition.

To the best of my knowledge as a health care professional, I certify that I do not have any symptoms or conditions which indicate I may have tuberculosis as of this time.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_