



STATE OF MISSOURI
DEPARTMENT OF CORRECTIONS
WAIVER OF TUBERCULOSIS TESTING

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