

WHO Countries with High Tuberculosis Incidence Rates

(World Health Organization Global Tuberculosis Control, http://www.who.int/tb/publications/global_report/en/)
Countries listed are at a 20 per 100,000 Incident Rate or higher

Afghanistan	Gabon	Pakistan
Albania	Gambia	Palau
Algeria	Georgia	Panama
Angola	Ghana	Papua New Guinea
Anguilla	Greenland	Paraguay
Argentina	Guam	Peru
Armenia	Guatemala	Philippines
Azerbaijan	Guinea	Portugal
	Guinea-Bissau	
Bangladesh	Guyana	Qatar
Belarus		
Belize	Haiti	Romania
Benin	Honduras	Russian Federation
Bhutan	Herzegovina	Rwanda
Bolivia		
Bosnia	India	Sao Tome & Principe
Botswana	Indonesia	Senegal
Brazil	Iraq	Sierra Leone
Brunei Darussalam		Singapore
Bulgaria	Kazakhstan	Solomon Islands
Burkina Faso	Kenya	Somalia
Burundi	Kiribati	South Africa
	Kuwait	South Sudan
Cabo Verde	Kyrgyzstan	Sri Lanka
Cambodia		Sudan
Cameroon	Lao PRD	Suriname
Central African Republic	Latvia	
Chad	Lesotho	Tajikistan
China	Liberia	Tanzania-UR
China, Hong Kong SAR	Libya	Thailand
China, Macao SAR	Lithuania	Timor-Leste
Colombia		Togo
Comoros	Madagascar	Tunisia
Congo	Malawi	Turkmenistan
Cote d'Ivoire	Malaysia	Tuvalu
	Maldives	
Djibouti	Mali	Uganda
Democratic Rep. of the Congo	Marshall Islands	Ukraine
Dominican Republic	Mauritania	United Arab Emirates
	Mexico	Uruguay
Ecuador	Micronesia	Uzbekistan
El Salvador	Moldova- Rep	
Equatorial Guinea	Mongolia	Vanuatu
Eritrea	Morocco	Venezuela
Eswatini	Mozambique	Viet Nam
Ethiopia	Myanmar	
		Yemen
Fiji	Namibia	
French-Polynesia	Nauru	Zambia
	Nepal	Zimbabwe
	Nicaragua	
	Niger	
	Nigeria	
	Niue	
	Northern Mariana Islands	

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TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE

Name: _____
Last name (please print) First Name (please print) ID#

Southern email address Phone number Birth date

All incoming students and those who have recently traveled outside of the USA will complete the TB screening questionnaire. If testing is required, the process could take up to two weeks to complete. **DO NOT WAIT UNTIL THE LAST MOMENT.**

Tuberculosis, also known as TB, is a bacterial infection that attacks the lungs and, sometimes, other parts of the body. It is spread when someone infected with the disease coughs or sneezes and the bacteria is inhaled by someone nearby. For additional information on TB: www.cdc.gov/tb/publications/factsheets/default.htm

PLEASE CIRCLE YES OR NO TO THE FOLLOWING QUESTIONS:

- | | | |
|--|-----|----|
| 1. Have you ever had a tuberculosis (TB) test that was positive, been diagnosed with or treated for TB disease? | YES | NO |
| 2. Have you ever been a health care worker, volunteer, or employee of a nursing home, prison, homeless shelter, or other residential institution? | YES | NO |
| 3. Have you ever been in close contact with someone known to have active tuberculosis (TB)? | YES | NO |
| 4. Were you born in a country listed on the back page of this form?
(If you were born in the United States of America, please circle "NO")
Please list country of birth: _____ | YES | NO |
| 5. Have you ever spent more than 1 month at one time in a country that is listed on the back?
Please list the country: _____ | YES | NO |

If you have answered **NO** to all of the above questions, no further testing will be required.

If you have answered **YES** to any of the above questions, you are required to provide documentation of a tuberculosis test dated no sooner than 6 months prior to registration.

1. If you have received prior treatment for active TB disease, you will need to provide proper documentation of such treatment to the University Health Center.
2. If you have had a positive TB test in the past or a BCG vaccine, you may be required to have lab work done instead of a TB skin test.

All tests can be done at the University Health Center, or by your health care provider. All medical expenses will be the individual's financial responsibility.

To the best of my knowledge, the information provided above is true and complete. I acknowledge that non-compliance will result in the student not being eligible to continue with classes.

Signature _____ Date _____

Return this form to the University Health Center by mail, fax, or email.

For office use only: _____
Reviewed by _____ Date _____

Follow up required: YES NO