Certificate of Completion

Tuberculosis Risk Assessment and/or Examination

This form is to satisfy **job/school-related requirements** in the California Education Code, Sections 49406 and 87408.6 and the California Health and Safety Code, Sections 1597.005, 121525, 121545 and 121555.

Individual assessed and/or examined:

_____	_____	_____	_____	_____@cougars.csusm.edu
Last Name	First Name	M.I.	Student ID number	Student Email Address

Date of assessment and/or examination: _____ (mo/day/yr)

The above named individual has submitted to a tuberculosis risk assessment. This individual does not have risk factors, or if tuberculosis risk factors were identified, this individual has been examined and determined to be free of infectious tuberculosis. (*Must be signed by the health care provider completing the risk assessment and/or examination*)

_____	_____	_____
Medical Provider (MD, DO, NP or PA) Signature	Medical Provider Printed Name	CA license number

333 S. TWIN OAKS VALLEY ROAD	SAN MARCOS	CA	92096-0001
Office Address: Street	City	State	Zip Code

(760) 750-4915	(760) 750-3181
Office phone number	Office fax number