

Registration Form TB Update & Skin Test Certification Course

Date of Registration: _____ Location of Training: _____ OR ____ (online)

Name: _____

Home address:
(street, city, state, zip) _____

I understand that as part of this training, (if, in person), I will practice giving TB skin tests to my classmates, and they will practice giving a TB skin test to me. In consideration of the opportunity to receive this training, I agree to release the Georgia Department of Public Health and hold it harmless for any injuries or other consequences of those practice tests.

Signature: _____

Please check:

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MD	PA	NP	RN	LPN	Paraprofessional	Epidemiologist	Outreach Worker/CDS	Administrative
<input type="checkbox"/> Other (specify) _____								

Employer: _____

Position: _____

Employer address: _____

City: _____ State: _____ Zip: _____

Work Phone: _____ Fax: _____ Home Phone: _____

Email: _____

Please check type of facility:

<input type="checkbox"/> Health Department <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Home <input type="checkbox"/> Mental Health <input type="checkbox"/> Hospice <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Home Health	<input type="checkbox"/> Physician's Office <input type="checkbox"/> Out Patient Clinic <input type="checkbox"/> Personal Care Home <input type="checkbox"/> HIV/AIDS affiliation <input type="checkbox"/> Community Based Organization <input type="checkbox"/> Shelter <input type="checkbox"/> School	<input type="checkbox"/> County or City Jail <input type="checkbox"/> Federal Prison <input type="checkbox"/> State DOC <input type="checkbox"/> Juvenile Detention <input type="checkbox"/> Other _____
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How do you plan to use this training?

Patient Care Employee Health Duties Teaching
 Infection Control Duties Other (specify) _____

E-mail completed form to TBNurse@dph.ga.gov