Georgia Department of Public Health, Tuberculosis Program

Registration Form
TB Update & Skin Test Certification Course

Date of Training: _____ Location (for live class): _____ **OR** Online (check)_____

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

I understand that as part of **the live** training, 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 (for live class): _____

Please check:

☐ MD ☐ PA ☐ NP ☐ RN ☐ LPN ☐ Paraprofessional ☐ Epidemiologist ☐ Outreach Worker/CDS ☐ Administrative
☐ Other (specify)_____

Employer:_____

Position:_____

Employer address:_____

City:_____ State:_____ Zip:_____

Work Phone:_____ Fax:_____ Home Phone:_____

Email:_____

Please check type of facility:

☐ Health Department	☐ Physician's Office	☐ County or City Jail
☐ Hospital	☐ Out Patient Clinic	☐ Federal Prison
☐ Nursing Home	☐ Personal Care Home	☐ State DOC
☐ Mental Health	☐ HIV/AIDS affiliation	☐ Juvenile Detention
☐ Hospice	☐ Community Based Organization	☐ Other _____
☐ Substance Abuse	☐ Shelter	
☐ Home Health	☐ School	

How do you plan to use this training?

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

Scan and e-mail completed form to TBNurse@dph.ga.gov

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