

**Health Sciences Immunization Program (HSIP)  
Annual Individual TB Risk Assessment Form**

An Individual TB Risk Assessment is required to be completed annually. Please indicate yes or no for each question. If a yes is indicated for any of the questions, you will be required to complete the HSIP TB Symptoms Survey (TBSS) Questionnaire.

Student last name: \_\_\_\_\_ Student first name: \_\_\_\_\_

Student ID#: \_\_\_\_\_ UW NetID: \_\_\_\_\_

**Health Care Personnel (HCP) should be considered at increased risk for TB if any of the following statements are marked “Yes”:**

<p>Temporary or permanent residence of <math>\geq 1</math> month in a country with a high TB rate within the last year To determine if the country you visited <math>\geq 1</math> month has a high TB rate, please use the <a href="#">WHO identified high burden countries</a> list for TB.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Current or planned immunosuppression, including human immunodeficiency virus (HIV) infection, organ transplant recipient, treatment with tumor necrosis factor-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone <math>\geq 15</math> mg/day for <math>\geq 1</math> month) or other immunosuppressive medication</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Close contact with someone who has had infectious TB disease since the last TB test within the last year</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Adapted from: [HCP Baseline Individual TB Risk Assessment](#) form developed by the Center for Disease Control and Prevention (CDC)

Sosa LE, Njie GJ, Lobato MN, et al. Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC, 2019. MMWR Morb Mortal Wkly Rep 2019;68:439–443. DOI: <http://dx.doi.org/10.15585/mmwr.mm6819a3>

Student Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_