FOOD SAFETY BRANCH
99-945 HALAWA VALLEY STREET
AIEA, HAWAII 96701
TELEPHONE NUMBER: (808) 586-8000 FAX: (808) 586-8040

STATE OF HAWAII
DEPARTMENT OF HEALTH

TUBERCULOSIS AND SYPHILIS REPORT FORM

NAME: LAST – FIRST – MIDDLE *(Type or Print)*	SEX	DATE OF BIRTH

STREET ADDRESS AND APARTMENT NO.	CITY	STATE	ZIP CODE

MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	CITY	STATE	ZIP CODE

Sign your name in INK as it appears on your application, in the presence of the examinating physician, for identification purposes.

APPLICANT SIGNATURE	DATE

Tuberculosis Test:

Date of Test Result: _____

Type of Test: (circle one) Skin Test X-Ray Result: _____

_____ _____
Signature Licensed Medical Provider (physician, nurse, etc.) Date

_____ _____
Type or Print Name of Licensed Medical Provider (physician, nurse, etc.) Title

_____
Business Name and Address

Syphilis Blood Test:

Date of Test Result: _____

Type of Test: _____ Result: _____

_____ _____
Signature Licensed Medical Provider (physician, nurse, etc.) Date

_____ _____
Type or Print Name of Licensed Medical Provider (physician, nurse, etc.) Title

_____
*Business Name and Address (If different from tuberculosis section)