SCHOOL ADMINISTRATION BUILDING

915 Court Street
P. O. Box 2497
Lynchburg, VA 24505-2497
www.lcsedu.net

TUBERCULIN TEST CERTIFICATE
SCHOOL EMPLOYEES

TO: **All Lynchburg City School Employees**

FROM: **Department for Personnel**

A. TO BE COMPLETED BY THE EMPLOYEE:

Name________________________________ **SSN**____________________________

Location ______________________________ **Position** ________________________

School Year ___________________________ **Phone No.**______________________

B. MUST BE COMPLETED AND SIGNED BY A LICENSED PHYSICIAN:

On the basis of a tuberculosis risk assessment, tests and/or other examinations, I hereby certify that the above-named person is believed free of communicable tuberculosis, this date being ____.

I am a licensed physician in ____
(State or District), United States

_______________________________________**M.D.**
Signature

____
Address

____
Phone Number

If you wish to obtain the services of ***Physicians Treatment Center****, their facility is located at* ***2832 Candlers Mt. Rd., (across from Little Ceasar & next to J. D. Byryder) Lynchburg, VA 24502 – (434) 239-3949****.* **The cost is $12.00.**

THIS FORM MUST BE RETURNED TO THE DEPARTMENT FOR PERSONNEL PRIOR TO THE START OF EMPLOYMENT WITH LYNCHBURG CITY SCHOOLS