### *[Replace this text with your organization’s identifier.]*

***[TST LETTER TO STAFF of EXPANDED GROUP of CONTACTS]***

***[Date]***

Dear Staff Member:

On ***[date]*** it came to our attention that a person associated with ***[Replace text with school name]*** had been diagnosed with active tuberculosis (TB).

The TB investigation has confirmed that some persons exposed to the TB patient at the school were infected with TB. Because of this finding, we will be testing additional staff, including you.

Because of this finding we will be testing additional staff members.

You were NOT initially identified as exposed to the person with active TB, but since TB transmission has been documented in some persons at the school who spent time with the TB patient, we are expanding the contact investigation.

**2 options to be evaluated for TB**

**Option 1**

***[Insert site (e.g. school name or HD) and FREE if there is no charge for services]***

***[Replace text with school and/or County HD name]*** will be giving tuberculin skin tests (TST) to all people who have been notified that they may have been in contact with the person with TB.

The TB skin tests will be given on ***[day], [date]*** from ***[time]*** to ***[time]*** in the ***[location]***. You must return to have the TB skin test read within 48-72 hours of receiving the test; otherwise, the test is invalid. Reading of the skin test will take place on ***[day], [date]*** from ***[time]*** to ***[time]*** in the ***[location]***. **A self-reported TB skin test reading of the result is not acceptable.**

**Complete the enclosed consent form and health questionnaire and bring them BOTH with you to be tested for TB at the *[Insert location]* on *[date]* at *[time].***

If the result of the TB skin test is positive, you will be contacted by ***[county]*** Health Department staff to arrange for further evaluation. If you have questions, see call-in information at the end of this letter.

**Option 2 on next page**

**Option 2**

If you choose to be tested by your private provider, we will still need documentation of the results mailed to us no later than ***[date]***. If you choose to use this option, you will be responsible for all charges related to this TB evaluation.

**When you go to your private provider:**

* **Take this LETTER**
* **Take the blank Private Provider TB Evaluation Form and ask the provider to COMPLETE it and send it to:**

**[*County name and address, attn.: the person collecting results] no later than [date].***

**On the day of testing at the *[insert school or health department here]* on *[date and location of testing]***

**Bring:**

* Your completed HEALTH QUESTIONNAIRE
* Your signed Your signed The OPTION FOR PRIVATE PROVIDER TB TESTING FORM

Please refer to the **TB FACT SHEET** that is included with this letter ***[download fact sheet from CDC or your program]***. You may call the ***[county name]*** Public Health Department for additional information at ***[telephone number].***

We assure you that ***[school name]*** School and the ***[county name]*** County Public Health Department are working together to identify and evaluate anyone who shared air with the person with TB disease. We thank you for your understanding and cooperation during the testing period.

Sincerely,

***[County Name]*** Health Officer/Deputy Director Principal, ***[school name]*** School

**Enclosures:**

**TB Fact Sheet**

**Blank Consent Form**

**Blank Health Questionnaire**

**Blank Private Provider TB Evaluation Form**

**Optional Choice for Private Provider TB Testing Form**