Infectious Disease Control Unit
PPD Agreement for Texas Health Steps Providers

Please Print

Facility Name: ____

Address: ______________________(City, State)__________(Zip)________

Provider Name: ______________________ Provider Title: ______________

Contact Name: ______________________ Contact Title: ______________

Contact Phone: ______________________ Contact Fax: ______________

In order to receive State-supplied PPD at no cost to me, I, on behalf of myself and any and all practitioners associated with this medical office, group practice, health department, community/migrant/rural health clinic, or other organization of which I am the physician in charge or equivalent, agree to the following:

1. I agree to provide/arrange training for all personnel in administering, reading, and recording the TB skin test results. I agree to instruct all patients that the TB skin test is a two (2)-part test and they must return in 48 to 72 hours for their test to be read by trained personnel so the test result can be documented. I agree to have all results documented in millimeters and a negative test will be recorded as 0 mm not negative. I agree to supply written documentation of the training to administer TB skin testing, reading and recording upon request of the health department issuing the PPD.
2. I agree to do the screening for TB risk factors on each patient and **ONLY** place the TB skin test on those patients that have a **TB risk factor or have some other medical necessity that is documented in their chart or are entering foster care**.
3. I agree to submit TB-400 forms or refer clients to the health department for medical evaluation or additional follow-up when they have latent TB infection (positive skin test result and a negative chest x-ray).
4. In accordance with the Texas Administrative Code, Title 25, Part 1, Chapter 97, Subchapter A, I shall report to the local health authority any known or suspected case of TB within one working day and any new diagnosis of latent TB infection within one week.
5. I agree to submit the Monthly Tuberculin Skin Testing Form (EF12-12168). This form will be sent at the first of each month showing our TB testing numbers for the previous month. I agree to monitor my stock levels so that emergency orders will be kept to a minimum.
6. As a private clinic or health care facility, I agree to use this PPD only for TB screening of children as part of a Texas Health Steps medical check-up and to identify and document TB risk factors before placing the PPD.
7. Either the State or I may terminate this agreement at any time. My failure or the failure of any others outlined above to comply with these requirements will be grounds for the State to terminate this agreement.

______________________________ ______________________

Provider Signature Date

Sign and Return to:

A copy of this agreement will be returned to you.

______________________________ ______________________

Health Department Representative Signature Date

EF12-12105 PPD Agreement (Rev. 6/05)