Date: [Date]

To: [Foster Care Agency Name]
Address: [Agency Address]
City, State, Zip: [City, State, Zip]

RE: Tuberculosis Screening Clearance

Patient Name: [Foster Parent Full Name]
Date of Birth: [Date of Birth]

To Whom It May Concern,

This letter serves to certify that the individual named above has been screened for Tuberculosis (TB) in accordance with state licensing requirements for foster care providers.

Screening Results:

- **Type of Test:** [TB Skin Test (Mantoux) / IGRA Blood Test / Chest X-Ray]
- **Date Administered/Performed:** [Date]
- **Date Read (if applicable):** [Date]
- **Result:** [Negative / Normal]

Based on the clinical evaluation and test results, the individual is currently free from communicable tuberculosis and does not pose a health risk to children or others in a household setting.

This clearance is valid until [Expiration Date].

Sincerely,

[Signature of Healthcare Provider]

Provider Name: [Printed Name and Title]
Facility Name: [Clinic/Hospital Name]
Phone Number: [Phone Number]
License Number: [License Number]