Date: [Date]

Patient Name: [Patient Full Name]
Date of Birth: [Date of Birth]
Patient ID/Record Number: [ID Number]

To Whom It May Concern,

This letter serves to certify that the above-named individual has undergone screening for Tuberculosis (TB). The evaluation included the following:

- **TB Skin Test (PPD) / IGRA Blood Test Date:** [Date]
- **Result:** [Positive/Negative]
- **Chest X-Ray Date (if applicable):** [Date]
- **Chest X-Ray Result:** [Normal/Abnormal]

Based on the clinical evaluation and test results:

[ ] The individual has no evidence of active Tuberculosis disease.
[ ] The individual is free from communicable Tuberculosis and is cleared for work or school activities.

Provider Comments: [Enter any additional notes here]

Sincerely,

Signature: _____
Provider Name: [Physician/Provider Name]
Title: [Title/Credentials]
Facility Name: [Clinic/Hospital Name]
Phone Number: [Phone Number]