SECTION I: TO BE COMPLETED BY REQUESTOR

Name of Facility

Street Address

City ___________________________ Zip Code ___________________________ Telephone Number ___________________________

I hereby request that ___________________________________________________________ be admitted to the above name facility. This patient suffers from confirmed or suspected **Tuberculosis**, a communicable disease. As Administrator of the facility, I certify that the facility is capable of providing proper care for this patient, according to the current guidelines published by the Centers for Disease Control.

Date __________ Signature of Administrator

I, _____________________________, M.D. the Medical Director of the above named facility, request that the patient, who has confirmed or suspected **Tuberculosis**, be admitted to the facility.

Date __________ Signature of Medical Director

I, _____________________________, M.D. the attending physician for the above named facility, request that the patient, who has confirmed or suspected **Tuberculosis**, be admitted to the facility.

Date __________ Signature of Attending Physician

SECTION II: TO BE COMPLETED BY DIVISION OF LONG TERM CARE

Based upon the requests made on this form, and with the facility's and medical director's assurance that appropriate precautions to deal with the confirmed or suspected **Tuberculosis** has been taken, I hereby grant a waiver to the facility and give them permission for this patient to be admitted.

Date __________ Director, Division of Long Term Care
Indiana State Department of Health