



TUBERCULOSIS WAIVER REQUEST

State Form 46595 (R2/3-02)

Indiana State Department of Health-Division of Long Term Care

CONFIDENTIAL: This document contains patient information of a confidential nature.

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