271 E. First St.
Corning, NY 14830
Return this form via fax to (607) 962-2592

TUBERCULOSIS TEST

PATIENT NAME: _____

DATE OF TEST: _____

RESULTS: _____

READ ON: _____

PHYSICIAN/
NURSE: _____

SIGNATURE: _____ DATE: _____

Clinic	Number	Location

GROUP:

DOH:

If the individual is a no-show to the scheduled appointment, AIM will not authorize to reschedule until the balance of the previous appointment is paid in full to AIM.