





BCG Scar Declaration Form

Candidate Personal Information						
Title: Mr, Mrs, Ms,	Surname	First names		[DOB	
Miss, Dr						
Home Tel:	rk Tel:	Mobil	e:			
Home Address: GP Address:						
Confirmation of competence						
INDIVIDUALS VIEWING BCG SCARS MUST BE TRAINED AND COMPETENT TO DO SO						
I confirm that I am:						
An Occupational Health nurse skilled in viewing BCG scars						
					Please tick	
An Occupational Health Physician						
					Please tick	
A Physician who is competent and has undertaken the relevant training in viewing BCG scars						
					Please tick	
A nurse who has been deemed competent and has undertaken the relevant training in						
viewing BCG scars					Please tick	
Screening Results						
Please examine the skin at the distal insertion of the deltoid and look for a scar.						
Is there a scar on the skin over the deltoid, in a location consistent with a BCG Yes					No	
vaccination?						
If yes which side		Right		Left		
(To be completed by a Healthcare Professional)						
Declaration						
I hereby certify that I am competent in the administration and reading of mantoux skin testing and BCG Vaccination						
Name:		Scars. Occupational	Hoalth Don	artm	ont Stamp	
Date:		Occupational	Health Dep	artiii	ent Stainp	<u>, </u>
Signature:						
GMC/ NMC or other						
clinical regulated						
body Ref. No.						
Please note a stamp is required for this form to deemed valid						<u>o be</u>

*Please note incomplete or partially completed forms will be refused, this form is purely designed to obtain appropriate evidence for our screening process this in no way makes us liable for cost incurred for completing this form or any other forms that we may issue. *