Eleven Sisters
COMMUNITY SUPPORT SERVICES

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BCG SCAR DECLARATION

Section to be completed by Candidate

Title: Dr / Mr / Miss / Ms / Mrs **Other:** _____

Forename: _____ **Surname:** _____

D.O.B: _____ **Gender:** Male / Female / Other

Grade: **Speciality:**

Section to be completed by Healthcare Professional

Personal Details

Forename: _____ **Surname:** _____

Telephone: _____ **GMC/NMC PIN:** _____

Address: _____

_____

Confirmation of Competence

Individuals viewing BCG scar should be trained and competent to do so. Please tick the relevant box below.

I am an Occupational Health Nurse, skilled in viewing BCG scars. ☐

I am an Occupational Health Physician. ☐

I am a Physician who is trained and competent in viewing BCG scars. ☐

I am a Nurse who is trained and competent in viewing BCG scars. ☐

Confirmation of Competence Continued.

Screening Result

Please examine the skin at the distal insertion of the deltoid and look for a scar. Based upon your observation, please answer the following questions.

Is there a scar on the skin over the deltoid, in a location consistent with a BCG vaccination?	Yes / No
If so, on which side is the scar?	Right / Left

Declaration

I hereby certify that I am competent in the administration and reading of Mantoux skin testing and BCG vaccination scars.

Full Name: _____ **OH Department / Surgery Stamp:**

Date: _____

Signature: _____

Please note: A stamp is required in order for this form to be deemed valid.

Incomplete or partially completed forms will be refused.