Tuberculosis Surveillance & Testing Certification Registration Form
Initial and Recertification Process Form

PLEASE TYPE OR WRITE LEGIBLY AND COMPLETE ALL SECTIONS.

NAME: _____ DATE OF BIRTH: _____
(As listed on COVID vaccine registration)

TELEPHONE: _____ FAX: _____ EMAIL: (REQUIRED): _____

MAILING ADDRESS: _____
Street or P. O. Box City State Zip Code County

TITLE: ◯ RN ◯ LPN ◯ RPH ◯ NP ◯ PA ◯ MD Other (please specify):_____

PLACE OF EMPLOYMENT& ADDRESS: _____

EMPLOYER'S CONTACT NUMBER or EMAIL: _____

Workshop Date and Location: _____
1st Workshop Date and Location Requested

Workshop Time 8:30am-4:00pm: _____
2nd Workshop Date and Location Requested

In the event your first choice is unavailable your registration is moved to the 2nd choice AUTOMATICALLY

Registration Fee: $50.00

PAYMENT: PERSONAL CHECKS NOT ACCEPTED. CREDIT/DEBIT CARDS ACCEPTED ONLINE, visit
https://www.ms.gov/msdh/tb_certification

I am mailing a ◯ Company Check ◯ Certified Check ◯ Money Order ◯ Cashier's Check

REGISTRATION AGREEMENT:

I understand that masks may be required to attend based on host facility guidelines

I have completed the registration form and included an e-mail address as required. I acknowledge that registration is not final until **BOTH** the completed registration form and payment is received. I understand the registration fee is **not refundable unless** the workshop is cancelled. If it becomes necessary to change the registration, I understand that I must provide **written notification at least 14 days prior to the scheduled workshop** to **transfer** registration to another workshop or to another person without additional charge. Transfer to another person may be requested in writing less than 14 days prior to the workshop with a $15.00 transfer fee. The transfer will not be completed until a **$15.00 transfer fee** is received. Failure to attend the scheduled workshop or transfer the fee in advance forfeits the registration fee. No transfers/substitutions are accepted after the workshop begins. *Registration confirmation or workshop cancellation will be sent by email 14 days before scheduled workshop.*

Date: _____ Signature: _____

Send registration form and fee to:
MSDH Office of Tuberculosis and Refugee Health
P.O. Box 1700
Jackson, MS 39215-1700
Phone: (601) 576-7705 Fax: (601) 576-7520

www.healthyms.com/tb

STOP

NO WALK-INS WILL BE PERMITTED.

Mississippi State Department of Health

All workshops are contingent upon the minimum participant requirement being met. Workshops will not meet if less than 25 participants are registered 14 days in advance. "Registration" means that the participant has submitted a complete registration form and acceptable form of payment.
Space is limited at some sites.

FOR OFFICE USE ONLY

Amount:_____ Date Received:_____
Method of Payment:_____ Payment Number:_____