# Tuberculosis Surveillance & Testing Certification Registration Form

***Form for initial and recertification process***

**PLEASE TYPE OR WRITE LEGIABLY. COMPLETE ALL SECTIONS.**

**NAME**: _____

**TELEPHONE**: _____ **FAX:** _____

**EMAIL ADDRESS (REQUIRED)**: _____

**MAILING ADDRESS**: _____

**Street or P. O. Box** **City** **State** **Zip Code** **County**

**TITLE:** ☐ RN ☐ LPN ☐ RPH ☐ Other (*please specify, NO ABBREVIATIONS*) _____

**PLACE OF EMPLOYMENT& ADDRESS**: _____

**EMPLOYER'S CONTACT NUMBER or EMAIL**: _____

**Workshop Date and Location:**

**Workshop Time 8:15am-4:00pm:**

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

_____

**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 **Discounted Rate:** $40.00 *(ONLY if* **form & fee received** *14 days prior to the requested workshop)*

**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 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


**NO WALK-INS OR LATE ARRIVALS ARE PERMITTED.**

All workshops are contingent upon the minimum participant requirement being met. Workshops will not meet if fewer 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. *Limited spaces are available at some sites.*

**FOR OFFICE USE ONLY**

Amount: _____ Date Received: _____

Method of Payment: _____ Payment Number: _____

MS State Department of Health

Instructions for Form# 1181e

Title: TUBERCULOSIS SURVEILLANCE & TESTING CERTIFICATION FORM

Revision Date: 1/31/2020

Purpose: To provide a vehicle for registration and scheduling for training and certification in current methods, procedures, policies, techniques, rules and regulations regarding tuberculosis surveillance, reporting and testing.

Instructions: **PLEASE TYPE OR WRITE LEGIBALY. COMPLETE ALL SECTIONS.**

NAME: Enter full legal name.

TELEPHONE: Enter complete 10-digit telephone number that offers greatest access to you.

FAX: Enter complete 10-digit facsimile number where you can receive important information related to the certification and testing training.

EMAIL: Enter e-mail address most often accessed by you. This address will be used to provide confirmation of scheduling and enrollment and/or communicate scheduling/location changes or to request additional information.

PLACE OF EMPLOYMENT AND ADDRESS: Enter complete name of the company with which you are currently employed and the complete mailing address (post office box, street name and number, city, state, and zip code.)

EMPLOYEER'S CONTACT NUMBER OR EMAIL: Enter the best method of quickly contacting you through your employer should it become necessary to contact you regarding course scheduling or requirement changes.

WORKSHOP DATE AND LOCATION: 1st Workshop Date and Location Requested: Enter your first choice for the course date and location you wish to attend.

WORKSHOP DATE AND LOCATION: 2nd Workshop Date and Location Requested: Enter a second choice of course date and location in the event the first choice is no longer available. If the first choice is unavailable, your registration will automatically be moved to the second choice and will be reflected in your confirmation notice.

REGISTRATION FEE: The applicable fee is based on the date of receipt of BOTH the fee and the registration. Registration is NOT complete until both are received. Personal checks are not accepted: Credit/Debit cards are accepted online at https://www.ms.gov.msdh/tb_certification

METHOD OF PAYMENT: Fill the appropriate box to reflect the method of payment.

REGISTRSTION AGREEMENT: Read the entire agreement. If you agree to the agreement, date and enter your legal signature.

OFFICE USE ONLY:

AMOUNT: Enter the amount of payment received for this registrant.

DATE RECEIVED: Enter the date the payment was received.

METHOD OF PAYMENT: Enter the payment method.

PAYMENT NUMBER: Enter the check, transaction, or payment confirmation number as applicable.

Office Mechanics and Filing:

Registration forms are date stamped on receipt and filed by class date and location. Confirmation of course enrollment is e-mailed once registration form and fee payment are complete.

Retention Period: Six years – 5 years of the certification period plus one or after audit, whichever is latest.