Sindecuse Health Center
WESTERN MICHIGAN UNIVERSITY

(269) 387-3287
(269) 387-3204 fax

International Student
Tuberculosis Test Requirement

Western Michigan University requires international students from high-risk countries to submit results **in English** of a TB test prior to the start of classes. Students are **exempt** from this requirement if they were were born in one of these countries with a low rate of tuberculosis:

Afghanistan	**Chile**	**Iran**	**Saint Kitts and Nevis**	**Turks and Caicos Islands**
Albania	**Cook Islands**	**Ireland**	**Saint Lucia**	**Uganda**
American Samoa	**Costa Rica**	**Israel**	**Saint Vincent and the Grenadines**	**United Arab Emirates**
Andorra	**Croatia**	**Italy**	**Samoa**	**United Kingdom of Great Britain and Northern Ireland**
Antigua and Barbuda	**Cuba**	**Jamaica**	**San Marino**	**United States**
Aruba	**Curacao**	**Japan**	**Saudi Arabia**	**U.S. Virgin Islands**
Australia	**Cyprus**	**Jordan**	**Seychelles**	**Wallis and Futuna Islands**
Austria	**Czechia**	**Lebanon**	**Sint Maarten (Dutch part)**	**West Bank and Gaza Strip**
Bahamas	**Denmark**	**Luxembourg**	**Slovakia**	**Fmr. Yugoslav Republic of Macedonia**
Bahrain	**Egypt**	**Malta**	**Slovenia**	
Barbados	**Estonia**	**Monaco**	**Spain**	
Belgium	**Finland**	**Montserrat**	**Sweden**	
Bermuda	**France**	**Netherlands**	**Switzerland**	
Bonaire, Saint Eustatius and Saba	**French Polynesia**	**New Zealand**	**Tokelau**	
	Germany	**Niue**	**Tonga**	
British Virgin Islands	**Greece**	**Norway**	**Trinidad and Tobago**	
Canada	**Grenada**	**Oman**	**Turkey**	
Cayman Islands	**Hungary**	**Poland**		
	Iceland	**Puerto Rico**		

If you were not born in one of the countries listed; have lived in or traveled to a country with a high rate of TB; or have had close contact with anyone who has had active TB you are required to have a Mantoux skin test or QuantiFERON TB Gold test administered within three months prior to arriving at Western Michigan University.

If your TB test is negative or non-reactive when read by your medical provider:
- Send us your results in English.

Test results must be sent in English.

If your TB test is positive or reactive when read by your medical provider, you must send us your results in English and
- Obtain a chest x-ray from your medical provider (or at Sindecuse Health Center) and submit your test results in English. Do not send your x-ray film.
- If the chest x-ray is normal and you have no symptoms of active TB, you have inactive, latent TB.
- If you have an abnormal chest x-ray or symptoms of active TB, you may be required to have additional tests.

Test results must include your name, date of birth, WMU ID number (WIN) and the name, address and phone number of your provider. Send results in English to Sindecuse Health Center, Western Michigan University, 1903 W Michigan Ave, Kalamazoo MI USA 49008-5445 or fax: (269) 387-4494.

▶ _____

WIN (WMU IDENTIFICATION NUMBER) TODAY'S DATE BIRTH DATE

▶ _____

FAMILY NAME (PRINT) COUNTRY OF RESIDENCE

PLEASE PRINT CLEARLY

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Patient Information

This form must be completed for Sindecuse Health Center to bill your insurance company.

Patient

FULL LEGAL NAME (REQUIRED FOR HEALTH RECORDS)

WMU IDENTIFICATION NUMBER (WIN) IF KNOWN

DATE OF BIRTH (MM/DD/YY)

PREFERRED FIRST NAME AT WMU

LOCAL OR WMU ADDRESS

CITY

STATE ZIP

PHONE

SEX:
- ☐ FEMALE
- ☐ MALE

GENDER IDENTITY:
- ☐ FEMALE
- ☐ MALE
- ☐ TRANSFEMALE / MTF
- ☐ TRANSMALE / FTM
- ☐ TRANSGENDER
- ☐ GENDER NONCONFORMING
- ☐ DIFFERENT IDENTITY

Primary Insurance

☐ **USE AS PATIENT'S EMERGENCY CONTACT**

POLICY HOLDER 1

NAME

RELATIONSHIP TO PATIENT

DATE OF BIRTH (MM/DD/YY)

PHONE

ADDRESS

EMPLOYER

CITY

STATE ZIP

SEX: ☐ FEMALE ☐ MALE

INSURANCE 1

INSURANCE COMPANY

INSURANCE PHONE

CLAIM SUBMISSION ADDRESS

STATE ZIP

CONTRACT/POLICY NUMBER

GROUP NUMBER

Secondary Insurance or Emergency Contact

☐ **USE AS PATIENT'S EMERGENCY CONTACT**

POLICY HOLDER 2

NAME

RELATIONSHIP TO PATIENT

DATE OF BIRTH (MM/DD/YY)

PHONE

ADDRESS

EMPLOYER

CITY

STATE ZIP

SEX: ☐ FEMALE ☐ MALE

INSURANCE 2

INSURANCE COMPANY

INSURANCE PHONE

CLAIM SUBMISSION ADDRESS

STATE ZIP

CONTRACT/POLICY NUMBER

GROUP NUMBER

Patient Signature

I authorize Sindecuse Health Center to furnish information to my insurance carrier concerning my illness and treatments. **MEDICARE RECIPIENT AUTHORIZATION:** I request that payment of authorized Medicare benefits be made on my behalf for services furnished me by Sindecuse Health Center. I authorize Sindecuse Health Center to release to the Center for Medicare and Medicaid Services or its agents any information needed to determine these benefits or the benefits payable or related services.

X **PATIENT** OR GUARDIAN SIGNATURE

DATE

Mail this form to: Sindecuse Health Center, Western Michigan University, 1903 W Michigan Ave, Kalamazoo, MI 49008-5445
or fax to (269) 387-4494.

form 109 revised 4/18