



STATE OF WEST VIRGINIA  
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Joe Manchin III  
Governor

Martha Yeager Walker  
Secretary

STATE FACILITY TREATMENT AGREEMENT

Patient Name \_\_\_\_\_

Date: \_\_\_\_\_

I, \_\_\_\_\_, understand I have suspected or confirmed tuberculosis based on tuberculin skin test results, an abnormal chest film, laboratory findings and/or other diagnostic test results and have been prescribed a treatment regimen by a medical provider to treat this disease. If my disease goes untreated, there may be serious results such as:

- My illness may last longer or become more severe
- I may spread TB to others
- I may develop and spread drug-resistant TB
- I can die from TB

While obtaining treatment at \_\_\_\_\_, a state-owned facility, I agree to the following measures:

- Take the prescribed tuberculosis medications daily by direct observation
- Submit to necessary testing (sputa and blood specimens, chest x-rays) for evaluation as ordered by the physician
- Remain at above-mentioned institution until respiratory isolation is no longer required and a discharge plan approved by WV TB Control Program, the hospital and the \_\_\_\_\_ County Health Department may be implemented
- Wear a mask in accordance with the above-named facility's policy
- Refrain from drinking alcoholic beverages or using any drugs not ordered by the physician

The staff of the \_\_\_\_\_ County Health Department , WV TB Control Program and the above-mentioned institution is available to provide assistance/counseling to you concerning your tuberculosis disease and this treatment agreement.

By signing this treatment agreement I acknowledge that I have read and agreed to the above conditions.

Patient \_\_\_\_\_

Date \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_

TB-113