

# 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:** \_\_\_\_\_  
1<sup>st</sup> Workshop Date and Location Requested

**Workshop Time 8:30am-4:00pm:** \_\_\_\_\_  
2<sup>nd</sup> Workshop Date and Location Requested

*In the event your first choice is unavailable your registration is moved to the 2<sup>nd</sup> choice AUTOMATICALLY*

**Registration Fee: \$60.00**

**PAYMENT: PERSONAL CHECKS NOT ACCEPTED. CREDIT/DEBIT CARDS ACCEPTED ONLINE, visit**  
[https://www.ms.gov/msdh/tb\\_certification](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.healthymms.com/tb](http://www.healthymms.com/tb)

**STOP**



**NO WALK-INS WILL BE PERMITTED.**



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: \_\_\_\_\_