NAME *(Last, First, MI)*	1	2	3	4	5	6	7	8	9	10	11	12

DATE OF BIRTH	STATUS ☐ AD ☐ RET ☐ DEP	BRANCH ☐ ARMY ☐ NAVY ☐ MARINE ☐ AF ☐ OTHER (Specify)

SPONSOR	RANK	SSN	UNIT ADDRESS	DUTY PHONE

HOME ADDRESS *(Include Zip Code)*	HOME PHONE

ACTIVE CASE

ADMITTED ☐ YES ☐ NO	ADMITTED DATE	DISCHARGE DATE	*ATS CODE	CONTACTS CHECKED ☐ YES ☐ NO

CONTACT

☐ CLOSE ☐ CASUAL	CONTACT OF	DATE CONTACT TERMINATED

CONVERTER/REACTOR

SKIN TEST RESULTS			LAST NEGATIVE SKIN TEST		CONTACTS CHECKED
DATE	TYPE	SIZE	DATE	TYPE	☐ YES ☐ NO

DRUG REGIMEN

DATE STARTED	TYPE	DOSE	FREQUENCY	LENGTH OF THERAPY

**American Thoracic Society standard diagnostic and therapeutic code.*

DA FORM 3897-R, AUG 1990 Previous editions obsolete.

TUBERCULOSIS REGISTRY

USAPA V1.00

For use of this form, see AR 40-5; the proponent agency is the OTSG

REPORTED TO STATE/LOCAL HEALTH DEPARTMENT *(If yes, list name of State or Local Health Department and date reported.)*

☐ YES ☐ NO

X-RAY FINDINGS

DATE	TEST RESULTS	DATE	NOTES

RETURN VISIT ACTIONS *(Use pencil).*