

**TUBERCULIN PURIFIED PROTEIN DERIVATIVE (PPD)  
ORDER FORM**

**Fax** this request to:

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT  
TUBERCULOSIS CONTROL PROGRAM  
1000 SW JACKSON SUITE 210  
TOPEKA, KS. 66612-1274

**FAX: (785) 559-4224**

PLEASE TYPE OR PRINT CLEARLY. ILLEGIBLE WRITING MAY RESULT IN ERRONEOUS MAILING DESTINATION

FACILITY NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

PHONE: (\_\_\_\_) \_\_\_\_\_ FAX: (\_\_\_\_) \_\_\_\_\_

CONTACT EMAIL ADDRESS: \_\_\_\_\_

PPD Purchase Order		
Item	Quantity	Price per vial
10 Test Vial		\$10.00
50 Test Vial		\$28.00

PPD High-Risk Order	
Item	Quantity
10 Test Vial	
50 Test Vial	
Must Report all usage on KDHE PPD tracking form	

**POLICIES ON THE PROVISION OF TBERCULOSIS PURIFIED PROTEIN DERIVATIVE (PPD)**

1. Reasonable charges may be made to the patient for this purchased PPD.
2. **KDHE will provide PPD test solution for Mantoux skin testing at no cost to local health departments, jails, prisons, homeless shelters and high-risk primary care sites who have high-risk tuberculosis screening programs.**
3. The TB Control Program will ship PPD only to physical addresses. No P.O. Box shipments will be sent out. This is to assure expedition of the PPD reaching the facility quickly and maintaining a refrigerated state in shipping boxes packed with ice packs. Upon receipt, it is expected that the product will be unpacked and placed in a refrigerated space immediately.

**Acceptance of Conditions:** I have read the above policies pertaining to the provision of purchasing PPD from the State of Kansas and acknowledge that I will be invoiced for this PPD with payment expected within 30 days.

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_