**Directly Observed Therapy Agreement for Tuberculosis Treatment**

Patient Name Date of Birth Home Phone

Patient Address Work Phone

City ZIP Emergency Contact Person’s Name Health Department

Cell Phone Telephone Date

# I understand and agree that:

(patient’s name)

* The only way to get well is by taking my tuberculosis (TB) medicine exactly as my nurse or doctor tells me. If my disease goes untreated, there may be serious consequences: my illness may last longer or become more severe, I may spread TB to others, I may develop and spread drug-resistant TB, I may die from TB.
* I will be taking several medications for a long time (months or more) in order to kill the TB germs.
* I agree to cooperate with the supervised Directly Observed Therapy (DOT) program to help remind me to take my medicine and to make sure I complete my treatment and get well. In this program, a designated public health employee or a trained DOT worker is authorized as my agent to maintain possession of my medication and to be present when I take my TB medicine.
* I will participate in the DOT process.
* I will tell my DOT worker if I have any problems. I may be asked to go to to meet with a doctor or nurse and/or to have tests during my treatment.
* I know that if I miss my visits and do not take my treatment as scheduled, legal action may be taken.

# I, understand and agree that:

(Name of Public Health Representative/Title)

* I will keep the patient’s health data private.
* I will answer questions and concerns of the patient. I will help link the patient to other services as needed.
* I will promptly tell the doctor and/or nurse of anything out of the ordinary. I will give reports as needed.

Patient Signature Date

Public Health Nurse Signature Date

DOT Provider Signature Date