Directly Observed Therapy Agreement
Latent Tuberculosis Infection (LTBI)

Patient name (last) ____________________________________ (first) ___________________________
Date of birth _________________________________________
Guardian (if applicable) ____________________________________________

LTBI medications normally must be taken for ____ months. Certain regimens of LTBI medications should be administered through directly observed therapy (DOT) which is coordinated through the local health department, IHS (or tribal health department), or another designated entity.

DOT requires that you take your LTBI medications while being observed by a public health nurse or other designated staff as indicated below:

Location _______________________________________________________
Days: □ Monday  □ Tuesday  □ Wednesday  □ Thursday  □ Friday  □ Saturday  □ Sunday
Time ________________ am/pm

Your nurse may coordinate other days and times (eg. on the weekends) when you can take medications on your own. It is important to follow your DOT schedule as outlined.

I have read the above information, understand it, and agree to the conditions.

________________________________________________________      _____________________
Patient (or guardian) signature        Date

________________________________________________________      _____________________
Interpreter signature (if applicable)      Date

________________________________________________________      _____________________
Nurse/clinician signature       Date

☐ Copy of agreement given to patient ____________ (Initials)