U. S. Department of State

MEDICAL EXAMINATION FOR IMMIGRANT OR REFUGEE APPLICANT

For use with TB Technical Instructions 1991 and the DS-3024

OMB No. 1405-0113
EXPIRATION DATE: xx/xx/xxxx
ESTIMATED BURDEN: 10 minutes
(See Page 2 - Back of Form)

Photo

Name *(Last, First, MI)* _____ , _____ , _____

Birth Date *(mm-dd-yyyy)* _____ **Sex:** ☐ **M** ☐ **F**

Birthplace *(City/Country)* _____/

Present Country of Residence _____ **Prior Country**

U.S. Consul *(City/Country)* _____/

Passport Number _____ **Alien** *(Case)* **Number**

Date *(mm-dd-yyyy)* **of Medical Exam** _____ **Date** *(mm-dd-yyyy)* **of Prior Exam, if any** _____

Date Exam Expires *(6 months from examination date, if Class A or TB condition exists, otherwise 12 months) (mm-dd-yyyy)*

Exam Place *(City/Country)* _____/_____ **Panel Physician** *(name)*

Radiology Services *(name)* _____ **Screening Site** *(name)*

Lab *(name for syphilis/TB)* _____ /

(1) Classification *(check all boxes that apply):*

☐ **No apparent defect, disease, or disability** *(see Worksheets DS-3024, DS-3025 and DS-3026)*

Class A Conditions *(From Past Medical History and Physical Examination Worksheets)*

☐ TB, active, infectious *(Class A, from Chest X-Ray Worksheet)*
☐ Syphilis, untreated
☐ Chancroid, untreated
☐ Gonorrhea, untreated
☐ Granuloma inguinale, untreated
☐ Lymphogranuloma venereum, untreated
☐ Hansen's disease, untreated multibacillary
☐ Addiction or abuse of specific* substance
☐ Any physical or mental disorder *(including other substance-related disorder)* with harmful behavior or history of such behavior likely to recur

*amphetamines, cannabis, cocaine, hallucinogens, opioids, phencyclidines, sedative-hypnotics, and anxiolytics

Class B Conditions *(From Past Medical History and Physical Examination Worksheets)*

☐ TB, active, noninfectious *(Class B1, from Chest X-Ray Worksheet)*
Treatment: ☐ None ☐ Partial ☐ Completed

☐ TB, inactive *(Class B2, from Chest X-Ray Worksheet)*
Treatment: ☐ None ☐ Partial ☐ Completed

☐ See Section 4 on page 2 for TB treatment details

☐ Syphilis *(with residual deficit)*, treated within the last year

☐ Current pregnancy, number of weeks pregnant _____

☐ Other *(specify or give details on checked conditions from worksheets)* _____

_____

☐ Hansen's disease, treated multibacillary
Treatment: ☐ Partial ☐ Completed

☐ Hansen's disease, paucibacillary
Treatment: ☐ None ☐ Partial ☐ Completed

☐ Sustained, full remission of addiction or abuse of specific* substances

☐ Any physical or mental disorder *(excluding addiction or abuse of specific* substance but including other substance-related disorder)* without harmful behavior or history of such behavior unlikely to recur

*amphetamines, cannabis, cocaine, hallucinogens, opioids, phencyclidines, sedative-hypnotics, and anxiolytics

(2) Laboratory Findings *(check all boxes that apply):*

☐ **Not done**

Syphilis:

	Test name	Date(s) run *(mm-dd-yyyy)*	Negative	Positive	Titer 1	Notes
Screening			☐	☐		
Confirmatory			☐	☐		

Treated	If treated, therapy:	Date(s) treatment given *(3 doses for penicillin)*
☐ Yes	☐ Benzathine penicillin, 2.4 MU IM	
☐ No	☐ Other *(therapy, dose):E*	

(3) Immunizations *(See Vaccination Form, check all boxes that apply)* **Not required for refugee applicants.**

☐ Vaccine history complete

☐ Vaccine history incomplete, requesting waiver *(indicate type below)*

☐ Incomplete vaccine history, no waiver requested

☐ Blanket waiver ☐ Individual waiver

I certify that I understand the purpose of the medical examination and I authorize the required tests to be completed.

Applicant Signature	Panel Physician Signature	Date *(mm-dd-yyyy)*

(4) Tuberculosis Treatment Regimen

(Fill out if applicant has taken in the past, or is now taking TB medication. If drug doses or dates not known or not available, mark "unknown".)

☐ Check if therapy currently prescribed *(if current, don't mark "End Date")*

Medication	Dose/Interval *(i.e., mg/day)*	Start Date *(mm-dd-yyyy)*	End Date *(mm-dd-yyyy)*
☐ Isonaizid (INH)			
☐ Rifampin			
☐ Pyrazinamide			
☐ Ethambutol			
☐ Streptomycin			
☐ Other, specify			

Applicant's pre-treatment weight (kg) _____ Date *(mm-dd-yyyy)* _____

Remarks _____

PAPERWORK REDUCTION ACT AND CONFIDENTIALITY STATEMENTS

PAPERWORK REDUCTION ACT STATEMENT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time required for searching existing data sources, gathering the necessary documentation, providing the information and/or documents required, and reviewing the final collection. You do not have to supply this information unless this collection displays a currently valid OMB control number. If you have comments on the accuracy of this burden estimate and/or recommendations for reducing it, please send them to: PRA_BurdenComments@state.gov

CONFIDENTIALITY STATEMENT

AUTHORITIES: The information asked for on this form is requested pursuant to Section 212(a) and 221(d) and as required by Section 222 of the Immigration and Nationality Act. Section 222(f) provides that the records of the Department of States and of diplomatic and consular offices of the United States pertaining to the issuance and refusal of visas or permits to enter the United States shall be considered confidential and shall be used only for the formulation, amendment, administration, or enforcement of the immigration, nationality, and other laws of the United States. Certified copies of such records may, in the discretion of the Secretary of State, be made available to a court provided the court certifies that the information contained in such records is needed in a case pending before the court.

PURPOSE: The U.S. Department of State uses the facts you provide on this form primarily to determine your classification and eligibility for a U.S. immigrant visa. Individuals who fail to submit this form or who do not provide all the requested information may be denied a U.S. immigrant visa. Although furnishing this information is voluntary, failure to provide this information may delay or prevent the processing of your case.

ROUTINE USES: If you are issued an immigrant visa and are subsequently admitted to the United States as an immigrant, the Department of Homeland Security will use the information on this form to issue you a Permanent Resident Card, and, if you so indicate, the Social Security Administration will use the information to issue a social security number. The information provided may also be released to federal agencies for law enforcement, counterterrorism and homeland security purposes; to Congress and courts within their sphere of jurisdiction; and to other federal agencies who may need the information to administer or enforce U.S. laws. More information on the Routine Uses for this collection can be found in the System of Records Notice State-24, Medical Records.