





U. S. Department of State  
**MEDICAL EXAMINATION FOR  
 IMMIGRANT OR REFUGEE APPLICANT**

OMB No. 1405-0113  
 EXPIRATION DATE: 05/31/2007  
 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/County) \_\_\_\_\_ / \_\_\_\_\_  
 Present Country of Residence \_\_\_\_\_ Prior Country \_\_\_\_\_  
 U. S. Consol (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 HIV/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)**

- |   |   |
|---|---|
| <input type="checkbox"/> TB, active, infectious (Class A, from Chest X-Ray Worksheet) | <input type="checkbox"/> Human immunodeficiency virus (HIV)   |
| <input type="checkbox"/> Syphilis, untreated  | <input type="checkbox"/> Hansen's disease, lepromatous or multibacillary  |
| <input type="checkbox"/> Chancroid, untreated   | <input type="checkbox"/> Addiction or abuse of specific* substance without harmful behavior   |
| <input type="checkbox"/> Gonorrhea, untreated   | <input type="checkbox"/> Any physical or mental disorder (including other substance-related disorder) with harmful behavior or history of such behavior likely to recur |
| <input type="checkbox"/> Granuloma inguinale, untreated                               |   |
| <input type="checkbox"/> Lymphogranuloma venereum, untreated                          |   |
- \*amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics

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

- |   |  |
|---|--|
| <input type="checkbox"/> TB, active, noninfectious (Class B1, from Chest X-Ray Worksheet)<br>Treatment: <input type="checkbox"/> None <input type="checkbox"/> Partial <input type="checkbox"/> Completed   | <input type="checkbox"/> Hansen's disease, prior treatment   |
| <input type="checkbox"/> TB, inactive (Class B2, from Chest X-Ray Worksheet)<br>Treatment: <input type="checkbox"/> None <input type="checkbox"/> Partial <input type="checkbox"/> Completed<br>See Section #4 on page 2 for TB treatment details | <input type="checkbox"/> Hansen's disease, tuberculoid, borderline, or paucibacillary  |
| <input type="checkbox"/> Syphilis (with residual deficit), treated within the last year   | <input type="checkbox"/> Sustained, full remission of addiction or abuse of specific* substances   |
| <input type="checkbox"/> Other sexually transmitted infections, treated within last year  | <input type="checkbox"/> 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 |
| <input type="checkbox"/> Current pregnancy, number of weeks pregnant _____  | *amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics   |
| <input type="checkbox"/> Other (specify or give details on checked conditions from worksheets) _____  |  |

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

**Syphilis:**  Not done

	Test name	Date(s) run (mm-dd-yyyy)	Negative	Positive	Titer 1	Notes
Screening			<input type="checkbox"/>	<input type="checkbox"/>		
Confirmatory			<input type="checkbox"/>	<input type="checkbox"/>		
Treated	If treated, therapy:				Dates(s) treatment given (3 doses for penicillin)	
<input type="checkbox"/> Yes	<input type="checkbox"/> Benzathine penicillin, 2.4 MU IM					
<input type="checkbox"/> No	<input type="checkbox"/> Other (therapy, dose):E					

**HIV:**  Not done

	Test name	Date(s) run (mm-dd-yyyy)	Negative	Positive	Indeterminate	Notes
Screening			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Secondary			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Confirmatory			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**(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")

<u>Medication</u>	<u>Dose/Interval</u> <u>(i.e. mg/day)</u>	<u>Start Date</u> <u>(mm-dd-yyyy)</u>	<u>End Date</u> <u>(mm-dd-yyyy)</u>
<input type="checkbox"/> Isoniazid (INH)	_____	_____	_____
<input type="checkbox"/> Rifampin	_____	_____	_____
<input type="checkbox"/> Pyrazinamide	_____	_____	_____
<input type="checkbox"/> Ethambutol	_____	_____	_____
<input type="checkbox"/> Streptomycin	_____	_____	_____
<input type="checkbox"/> Other, specify	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Applicant's weight (kg) \_\_\_\_\_

Remarks \_\_\_\_\_

**PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES**

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 data, providing the information required, and reviewing the final collection. Persons are not required to provide this information in the absence of a valid OMB approval number. Send comments on the accuracy of this estimate of the burden and recommendations for reducing it to: U.S. Department of State (A/RPS/DIR) Washington, DC 20520.

We ask for information on this form, in the case of applicants for immigrant visas, to determine medical eligibility under INA Sections 212(a) and 221(d), and, in the case of refugees, as required under INA Section 412(b)(4) and (5). If an immigrant visa is issued or refugee status granted, you will convey this information to U.S. Department of Homeland Security (DHS) for disclosure to the Centers for Disease Control and Prevention and to the U.S. Public Health Service. Failure to provide this information may delay or prevent the processing of your case. If an immigrant visa is not issued or refugee status is not granted, this form