



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** \_\_\_\_\_

**Radiology Services** \_\_\_\_\_ **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, untreated 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, treated multibacillary<br>Treatment: <input type="checkbox"/> Partial <input type="checkbox"/> Completed  |
| <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, paucibacillary<br>Treatment: <input type="checkbox"/> None <input type="checkbox"/> Partial <input type="checkbox"/> Completed  |
| <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:			Date(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> <i>(i.e., mg/day)</i>	<u>Start Date</u> <i>(mm-dd-yyyy)</i>	<u>End Date</u> <i>(mm-dd-yyyy)</i>
<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 pre-treatment weight (kg) \_\_\_\_\_ Date (mm-dd-yyyy) \_\_\_\_\_

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 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: A/ISS/DIR, Room 2400 SA-22, U.S. Department of State, Washington, DC 20522-2202

**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 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.