

User Interface Design Presentation

CEAC Medical OMB Submission Part 3



DS-3024e: Getting Started Page

Displayed for all users requiring use of the 3024e form.

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Chest X-Ray And Classification Worksheet (DS-3024e)

Getting Started

NOTE: If there is no activity for 20 minutes or more in the process of completing this online application, your session will expire and some data might be lost. Data entered will be saved as you advance through the application by clicking the Next button. However, data on the current page will be lost if there is no activity for 20 minutes.

Click the button below to begin the Chest X-Ray And Classification Worksheet (DS-3024e)

The following instructions contain important information about completing this form. Please read all instructions carefully.

Instructions for completing the Chest X-Ray And Classification Worksheet (DS-3024e)

These forms can only be completed by panel physicians appointed by the Department of State. Please abide by the following guidelines in completing the forms:

1. Enter the information requested into the appropriate spaces in each window. Please answer all questions. Your answers must be in English and must use English characters, except when you are asked to provide your full name in your native alphabet. Letters like ñ, é, ú, ç are not recognized by the system. Please enter names like Muñoz and Semonin as Munoz and Semonin, unless otherwise asked.
2. Review the information you entered for accuracy.
3. All exams must be performed in accordance with the Centers for Disease Control and Prevention's (CDC) Technical Instructions and their updates.

Begin Resume Medical Form Process:

Continue

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- The user selects the 'Continue' button.

DS-3024e: Personal Information Page

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Chest X-Ray And Classification Worksheet (DS-3024e)

OMB CONTROL NUMBER: 1405-0113
FORM NUMBER: DS-3024e
EXPIRATION DATE: 04/30/2012
ESTIMATED BURDEN: 10 MIN

Personal Information

- Getting Started
- Personal
- Chest X-Ray Indication
- Chest X-Ray Findings
- Sputum Smears
- Classifications
- Follow-Up

Help: Navigation Buttons

Click on the buttons above to access previously entered data.

Case Number TKY2000744003 <input type="checkbox"/> Did Not Provide	A Number A123456789 <input type="checkbox"/> Did Not Provide
Surname SAMPLE	Given Name MARIA
Date of Birth 01 JUN 1951 (Format: DD-MMM-YYYY)	Current Age : 59
Passport	
Country/Authority That Issued Passport - SELECT ONE -	Passport Number <input type="checkbox"/> Did Not Provide

PAPERWORK REDUCTION ACT: 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/GIS/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 State 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.

[Back: Getting Started](#) [Save](#) [Next: Chest X-Ray Indication](#)



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- The following fields are required: 'Surname', 'Given Name', 'Date of Birth', 'Passport Number' or 'Does Not Apply', 'A Number' or 'Does Not Apply', 'Case Number' or 'Does Not Apply'.
- 'Date of Birth' can be a partial date for refugee applicants; must be a full date for all other applicant types.

DS-3024e: Chest X-Ray Indication Page

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Chest X-Ray And Classification Worksheet (DS-3024e)

Chest X-Ray Indication

Mark all that apply.

Summary of information from other pages

- History of Tuberculosis (TB) Disease
- Contact with Person with TB
- TB Signs or Symptoms
- Adult (With or without any of the other indications)
- None of the above

◀ Back: Personal Information Save Next: Chest X-Ray Findings ▶

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- If the applicant's age is 15 or over, the 'Adult' field must be selected.

DS-3024e: Chest X-Ray Findings Page

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Chest X-Ray And Classification Worksheet (DS-3024e)

Chest X-Ray Findings

No information is available from related pages.

Getting Started
Personal
Chest X-Ray Indication
Chest X-Ray Findings
Sputum Smears
Classifications
Follow-Up

Help: Navigation Buttons
Click on the buttons above to access previously entered data.

Date Chest X-Ray Taken:

(Format: DD-MMM-YYYY)

Findings:
 Normal
 Abnormal

Remarks **Optional*

This portion of the form is now ready to be signed. By clicking "Radiologist Signature," you are electronically signing this portion of the form. You are required to electronically sign this portion of the form yourself. Your electronic signature certifies that you have read and understood the questions on this portion of the form and that your answers are true and correct to the best of your knowledge and belief.

3/18/2011 10:00:01 AM

Radiologist Signature and Date Interpreted

I certify that all statements and answers that appear in this portion of the form are true and complete to the best of my knowledge and belief.

Enter your password:

Enter the code below as shown:
 

SAMPLE

SMTAGS



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- The user must select either 'Normal' or 'Abnormal' from 'Findings'.
- 'Date Chest X-Ray Taken' must be a full date.
- For the radiologist to sign, both the 'Chest X-Ray Indication' and 'Chest X-Ray Findings' pages must be completed.

DS-3024e: Chest X-Ray Findings Page

Displayed for all users requiring use of the 3024e form. Answered 'Normal Findings' to 'Findings', no additional fields are displayed.

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Chest X-Ray And Classification Worksheet (DS-3024e)

Chest X-Ray Findings

No information is available from related pages.

Date Chest X-Ray Taken:

(Format: DD-MMM-YYYY)

Findings:

Remarks **Optional*

This portion of the form is now ready to be signed. By clicking "Radiologist Signature," you are electronically signing this portion of the form. You are required to electronically sign this portion of the form yourself. Your electronic signature certifies that you have read and understood the questions on this portion of the form and that your answers are true and correct to the best of your knowledge and belief.

3/18/2011 10:00:01 AM

Radiologist Signature and Date Interpreted

I certify that all statements and answers that appear in this portion of the form are true and complete to the best of my knowledge and belief.

Enter your password:

Enter the code below as shown:



◀ Back: Chest X-Ray Indication  Save Next: Sputum Smears ▶



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DS-3024e: Chest X-Ray Findings Page

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Chest X-Ray And Classification Worksheet (DS-3024e)

Chest X-Ray Findings

No information is available from related pages.

Date Chest X-Ray Taken:
(Format: DD-MMM-YYYY)

Findings: **ABNORMAL FINDINGS**

(Indicate category and finding, checking all that apply, in the table below).

Yes No
 Can suggest ACTIVE TB (Need smears)

Yes No
 Infiltrate or consolidation
 Any cavitary lesion
 Nodule or mass with poorly defined margins (such as tuberculoma)
 Pleural effusion
 Hilar/mediastinal adenopathy with or without atelectasis
 Other (such as miliary findings)

Yes No
 Can suggest INACTIVE TB (Need smears if symptomatic)

Yes No
 Discrete fibrotic scar or linear opacity (fibrotic scar)
 Discrete nodule(s) without calcification
 Discrete linear opacity (fibrotic scar) with volume loss or retraction
 Other (such as bronchiectasis)

Yes No
 OTHER X-Ray Findings

Yes No
 Follow-Up Needed (mark as "Class B Other")

Yes No
 Musculoskeletal
 Cardiac
 Pulmonary, non-TB (e.g., emphysema)
 Other

No Follow-Up Needed for Pleural thickening, diaphragmatic tenting, calcified pulmonary nodule(s), calcified lymph node(s), calcified lymph node(s) with calcified pulmonary nodule(s), or minor musculoskeletal findings

Remarks *Optional

This portion of the form is now ready to be signed. By clicking "Radiologist Signature," you are electronically signing this portion of the form. You are required to electronically sign this portion of the form yourself. Your electronic signature certifies that you have read and understood the questions on this portion of the form and that your answers are true and correct to the best of your knowledge and belief.

3/18/2011 10:00:01 AM

Radiologist Signature and Date Interpreted

I certify that all statements and answers that appear in this portion of the form are true and complete to the best of my knowledge and belief.

Enter your password:

Enter the code below as shown:

Radiologist Signature

Back: Chest X-Ray Indication Save Next: Sputum Smears



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- If 'Abnormal' is selected, at least one of the following must be selected as 'Yes': 'Can suggest Active TB', 'Can suggest Inactive TB', or 'Other Findings'.
- All fields in the selected area must be answered 'Yes' or 'No'.

DS-3024e: Chest X-Ray Findings Page, Top

Displayed for all users requiring use of the 3024e form. Answered 'Abnormal Findings' to 'Findings', additional fields are displayed.

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Chest X-Ray And Classification Worksheet (DS-3024e)

Chest X-Ray Findings

No information is available from related pages.

Date Chest X-Ray Taken:

(Format: DD-MMM-YYYY)

Findings:

(Indicate category and finding, checking all that apply, in the table below).

Yes No
 Can suggest ACTIVE TB (Need smears)

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Infiltrate or consolidation
<input type="checkbox"/>	<input type="checkbox"/>	Any cavitary lesion
<input type="checkbox"/>	<input type="checkbox"/>	Nodule or mass with poorly defined margins (<i>such as tuberculoma</i>)
<input type="checkbox"/>	<input type="checkbox"/>	Pleural effusion ?
<input type="checkbox"/>	<input type="checkbox"/>	Hilar/mediastinal adenopathy with or without atelectasis
<input type="checkbox"/>	<input type="checkbox"/>	Other (<i>such as miliary findings</i>)

Yes No
 Can suggest INACTIVE TB (Need smears if symptomatic)

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Discrete fibrotic scar or linear opacity (<i>fibrotic scar</i>)
<input type="checkbox"/>	<input type="checkbox"/>	Discrete nodule(s) without calcification
<input type="checkbox"/>	<input type="checkbox"/>	Discrete linear opacity (<i>fibrotic scar</i>) with volume loss or retraction
<input type="checkbox"/>	<input type="checkbox"/>	Other (<i>such as bronchiectasis</i>)

CEAC Medical OMB Package

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DS-3024e: Chest X-Ray Findings Page, Bottom

Displayed for all users requiring use of the 3024e form. Answered 'Abnormal Findings' to 'Findings', additional fields are displayed.

Yes No
 OTHER X-Ray Findings

Yes No
 Follow-Up Needed (mark as "Class B Other")

Yes No
 Musculoskeletal
 Cardiac
 Pulmonary, non-TB (e.g., emphysema)
 Other

No Follow-Up Needed for Pleural thickening, diaphragmatic tenting, calcified pulmonary nodule(s), calcified lymph node(s), calcified lymph node(s) with calcified pulmonary nodule(s), or minor musculoskeletal findings

Remarks **Optional*

This portion of the form is now ready to be signed. By clicking "Radiologist Signature," you are electronically signing this portion of the form. You are required to electronically sign this portion of the form yourself. Your electronic signature certifies that you have read and understood the questions on this portion of the form and that your answers are true and correct to the best of your knowledge and belief.


3/18/2011 10:00:01 AM

Radiologist Signature and Date Interpreted

I certify that all statements and answers that appear in this portion of the form are true and complete to the best of my knowledge and belief.

Enter your password:

Enter the code below as shown:



Radiologist Signature

◀ Back: Chest X-Ray Indication Save Next: Sputum Smears ▶



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DS-3024e: Sputum Smears Page

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Chest X-Ray And Classification Worksheet (DS-3024e)

Sputum Smears

Summary of information from other pages
X-Ray Findings: Normal

Sputum Smear Findings:
Yes No
 Applicant has signs or symptoms of TB

[← Back: X-Ray Findings](#) [Save](#) [Next: Classifications ▶](#)

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- The user must select either 'Yes' or 'No' for 'Applicant has signs or symptoms of TB'.

DS-3024e: Sputum Smears Page

Displayed for all users requiring use of the 3024e form. Answered 'Yes, Applicant has' to 'Sputum Smear Findings'.

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Chest X-Ray And Classification Worksheet (DS-3024e)

Sputum Smears

Summary of information from other pages
X-Ray Findings: Normal

Sputum Smear Findings:
Yes No
 Applicant has signs or symptoms of TB
(Mark all that apply)

Applicant has...

Signs or Symptoms of TB (See Chest X-Ray Indication page)
 X-Ray Suggests ACTIVE TB (See Chest X-Ray Findings page)

Sputum Smears

Result	Date Specimen Obtained (Format DD-MMM-YYYY)	
Smear 1: -SELECT ONE-	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Does not apply
Smear 2: -SELECT ONE-	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Does not apply
Smear 3: -SELECT ONE-	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Does not apply

Sputum Smears and X-Ray

At least One Smear Result POSITIVE and:
 Any Chest X-Ray Finding (Normal or Abnormal findings), this is **Class A/TB**

Three Smear Results NEGATIVE and:
 X-Ray Normal with:
 Signs or Symptoms Resolved, this is **No Class**
 Signs or Symptoms suggest follow-up needed after arrival, this is **B Other**

X-Ray suggests ACTIVE or INACTIVE TB, this is **Class B1/TB**
 OTHER X-Ray findings suggest follow-up needed after arrival, this is **Class B Other**

◀ Back: X-Ray Findings Save Next: Classifications ▶

- Positive
- Negative



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- If 'Yes' is selected to 'Applicant has signs or symptoms of TB', the following fields must be filled in:
 - 'Smear 1 Result' and 'Date Specimen Obtained'
 - 'Smear 2 Result' and 'Date Specimen Obtained' or 'Does Not Apply'
 - 'Smear 3 Result' and 'Date Specimen Obtained' or 'Does Not Apply'
- 'Date Specimen Obtained' must be a full date.

DS-3024e: Sputum Smears Page

Displayed for all users requiring use of the 3024e form. Answered 'Yes, Applicant has' to 'Sputum Smear Findings' and at least one of the 'Sputum Smear Results' is 'Positive', an additional field is enabled.

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Chest X-Ray And Classification Worksheet (DS-3024e)

Sputum Smears

Summary of information from other pages
X-Ray Findings: Normal

Sputum Smear Findings:
Yes No
 Applicant has signs or symptoms of TB
(Mark all that apply)

Applicant has...

Signs or Symptoms of TB (See Chest X-Ray Indication page)
 X-Ray Suggests ACTIVE TB (See Chest X-Ray Findings page)

Sputum Smears

Result	Date Specimen Obtained (Format DD-MMM-YYYY)	
Smear 1: <input type="text" value="NEGATIVE"/>	<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>	<input type="checkbox"/> Does not apply
Smear 2: <input type="text" value="NEGATIVE"/>	<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>	<input type="checkbox"/> Does not apply
Smear 3: <input type="text" value="POSITIVE"/>	<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>	<input type="checkbox"/> Does not apply

Sputum Smears and X-Ray

At least One Smear Result POSITIVE and:

Any Chest X-Ray Finding (Normal or Abnormal findings), this is **Class A/TB**

Three Smear Results NEGATIVE and:

X-Ray Normal with:

Signs or Symptoms Resolved, this is **No Class**
 Signs or Symptoms suggest follow-up needed after arrival, this is **B Other**

X-Ray suggests ACTIVE or INACTIVE TB, this is **Class B1/TB**
 OTHER X-Ray findings suggest follow-up needed after arrival, this is **Class B Other**

◀ Back: X-Ray Findings Save Next: Classifications ▶



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- If one of the smear results is 'Positive', the user should select the 'Any Chest X-Ray Finding' field.

DS-3024e: Sputum Smears Page

Displayed for all users requiring use of the 3024e form. Answered 'Yes, Applicant has' to 'Sputum Smear Findings' and all three of the 'Sputum Smear Results' are 'Negative', additional fields are enabled.

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Chest X-Ray And Classification Worksheet (DS-3024e)

Sputum Smears

Summary of information from other pages:
X-Ray Findings: Normal

Sputum Smear Findings:
Yes No
 Applicant has signs or symptoms of TB
(Mark all that apply)

Applicant has...

Signs or Symptoms of TB (See Chest X-Ray Indication page)
 X-Ray Suggests ACTIVE TB (See Chest X-Ray Findings page)

Sputum Smears

Result	Date Specimen Obtained (Format DD-MMM-YYYY)	
Smear 1: <input type="text" value="NEGATIVE"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Does not apply
Smear 2: <input type="text" value="NEGATIVE"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Does not apply
Smear 3: <input type="text" value="NEGATIVE"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Does not apply

Sputum Smears and X-Ray

At least One Smear Result POSITIVE and:
 Any Chest X-Ray Finding (Normal or Abnormal findings), this is **Class A/TB**

Three Smear Results NEGATIVE and:
 X-Ray Normal with:
 Signs or Symptoms Resolved, this is **No Class**
 Signs or Symptoms suggest follow-up needed after arrival, this is **B Other**

X-Ray suggests ACTIVE or INACTIVE TB, this is **Class B1/TB**
 OTHER X-Ray findings suggest follow-up needed after arrival, this is **Class B Other**

◀ Back: X-Ray Findings Save Next: Classifications ▶



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- If all three of the smear results are 'Negative', the user should select the appropriate classification.

DS-3024e: Sputum Smears Page

Displayed for all users requiring use of the 3024e form. Answered 'No, Applicant has' to 'Sputum Smear Findings', additional fields are displayed.

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Chest X-Ray And Classification Worksheet (DS-3024e)

Sputum Smears

Summary of information from other pages:
X-Ray Findings: Normal

Sputum Smear Findings:
Yes No
 Applicant has signs or symptoms of TB.
(Mark all that apply)

Applicant has no signs or symptoms of TB and...

- X-Ray Suggests INACTIVE TB, this is a **Class B2/TB**
- OTHER X-Ray Findings Suggest Follow-Up Needed after Arrival, this is **B Other**
- OTHER X-Ray Findings Suggest **No Follow-Up Needed**, this is **No Class**
- X-Ray Normal, this is **No Class**

◀ Back: X-Ray Findings Save Next: Classifications ▶


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- If 'No' is selected for 'Applicant has signs or symptoms of TB', the user should select the appropriate classification.

DS-3024e: Classifications Page

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Chest X-Ray And Classification Worksheet (DS-3024e)

Classifications

Mark all that apply. Also provide complete information on the DS-2053e.
A summary of classifications selected in the Sputum Smears page is below.

Summary of information from other pages

Follow-Up:
REMARKS:

No Class


Class A/TB

Class B1/TB

Class B2/TB

Class B Other

◀ Back: Smears Save Next: Follow-Up ▶

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- At least one classification must be selected.

DS-3024e: Follow-Up Page

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Chest X-Ray And Classification Worksheet (DS-3024e)

Follow-Up

If non-TB condition, specify condition below **and** on DS-2053e; include additional tests, and therapy used with start and stop dates and any changes.

If TB condition, enter information in DS-2053e TB Treatment Regimen.

Summary of information from other pages

X-Ray Findings: Normal

Help: Navigation Buttons

Click on the buttons above to access previously entered data.

Follow-Up Needed After Arrival?
- SELECT ONE -

- No follow-up needed
- Needed for TB Condition
- Needed for non-TB Condition

Remarks **Optional*

◀ Back: Classifications Save Next: Review ▶



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- The user must select one of the options from the 'Follow-up Needed After Arrival?' dropdown.

DS-3025e: Getting Started Page

Displayed for all users.

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Medical Examination For Immigrant Or Refugee Applicant (DS-3025e)

Getting Started

NOTE: If there is no activity for 20 minutes or more in the process of completing this online application, your session will expire and some data might be lost. Data entered will be saved as you advance through the application by clicking the Next button. However, data on the current page will be lost if there is no activity for 20 minutes.

Click the button below to begin the Electronic Vaccination Documentation Worksheet (DS-3025e)

The following instructions contain important information about completing this form. Please read all instructions carefully.

Instructions for completing the Electronic Vaccination Documentation Worksheet (DS-3025e):

These forms can only be completed by panel physicians appointed by the Department of State. Please abide by the following guidelines in completing the forms:

1. Enter the information requested into the appropriate spaces in each window. Please answer all questions. Your answers must be in English and must use English characters, except when you are asked to provide your full name in your native alphabet. Letters like ñ, é, ú, ç are not recognized by the system. Please enter names like Muñoz and Sémonin as Munoz and Semonin, unless otherwise asked.
2. Review the information you entered for accuracy.
3. All exams must be performed in accordance with the Centers for Disease Control and Prevention's (CDC) Technical Instructions and their updates.

Begin Resume Medical Form Process:

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- The user selects the 'Continue' button.

DS-3025e: Personal Information Page

Displayed for all users.

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COMPLETE REVIEW SIGN

Electronic Vaccination Documentation Worksheet (DS-3025e)

OMB CONTROL NUMBER: 1405-0113
FORM NUMBER: DS-3025e
EXPIRATION DATE: 04/30/2012
ESTIMATED BURDEN: 30 minutes

Personal Information

Case Number

 Did Not Provide

A Number

 Did Not Provide

Surname ⓘ

Given Name ⓘ

Sex
 Male Female

Date of Birth ⓘ

(Format: DD-MMM-YYYY)

Exam Date

(Format: DD-MMM-YYYY)

Passport

Country/Authority That Issued Passport

Passport Number

 Did Not Provide

PAPERWORK REDUCTION ACT: Public reporting burden for this collection of information is estimated to average 30 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/GIS/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 State 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.

◀ Back: Getting Started Save Next: Immunizations ▶



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- The following fields are required: 'Surname', 'Given Name', 'Sex', 'Exam Date', 'Date of Birth', 'Passport Number' or 'Did Not Provide', 'A Number' or 'Did Not Provide', 'Case Number' or 'Did Not Provide'.
- 'Date of Birth' can be a partial date for refugee applicants; it must be a full date for all other applicant types.
- 'Exam Date' must be a full date.

DS-3025e: Immunization Record Page 1

Displayed for all users. 'Completed Series' selected for all immunizations, no additional fields are displayed.

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Electronic Vaccination Documentation Worksheet (DS-3025e)

Immunizations for 6 years and younger

To be completed by Panel Physician Only: For refugee applicants, please complete only if reliable vaccination documents are available. Fill in all applicable information.

DT/DTP/DTap [X]

- DT
- DTP
- DTap

Specify Type: [- SELECT ONE -]

Given By Panel Physician: [] [] [] (Format: DD-MMM-YYYY)

Additional Information:
 Completed series
 Immune
 Blanket waiver(s) requested

Immunization Dates:
Click 'Add Date' to add an immunization date + Add Date

+ Add Another - Remove

Rotavirus [X]

Given By Panel Physician: [] [] [] (Format: DD-MMM-YYYY)

Additional Information:
 Completed series
 Immune
 Blanket waiver(s) requested

Immunization Dates:
Click 'Add Date' to add an immunization date + Add Date

Hib Haemophilus Influenzae Type B [X]

Given By Panel Physician: [] [] [] (Format: DD-MMM-YYYY)

Additional Information:
 Completed series
 Immune
 Blanket waiver(s) requested

Immunization Dates:
Click 'Add Date' to add an immunization date + Add Date

Hepatitis A [X]

Given By Panel Physician: [] [] [] (Format: DD-MMM-YYYY)

Additional Information:
 Completed series
 Immune
 Blanket waiver(s) requested

Immunization Dates:
Click 'Add Date' to add an immunization date + Add Date

Pneumococcal [X]

Given By Panel Physician: [] [] [] (Format: DD-MMM-YYYY)

Additional Information:
 Completed series
 Immune
 Blanket waiver(s) requested

Immunization Dates:
Click 'Add Date' to add an immunization date + Add Date

← Back: Personal Information Save Next: Immunizations, part 2 →

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- If a 'Vaccination Type' is selected, at least one vaccination date must be filled in.
- For all applicants other than refugees, all immunizations must have at least one date filled in.
- 'Immunization Dates' can be partial dates.
- 'Given by Panel Physician' must be a full date.

DS-3025e: Immunization Record Page 1

Displayed for all users. 'Immune' selected for all immunizations, additional fields are displayed.

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COMPLETE REVIEW SIGN

Electronic Vaccination Documentation Worksheet (DS-3025e)

Immunizations for 6 years and younger

To be completed by Panel Physician Only: For refugee applicants, please complete only if reliable vaccination documents are available. Fill in all applicable information.

DT/DTP/DtaP

Specify Type:
- SELECT ONE -

Given By Panel Physician: [] [] [] (Format: DD-MMM-YYYY)

Additional Information:
 Completed series
 Immune
 Blanket waiver(s) requested

Lab Test Date: [] [] [] [] (Format: DD-MMM-YYYY)

Immunization Dates:
Click 'Add Date' to add an immunization date + [Add Date](#) + Add Another - Remove

Rotavirus

Given By Panel Physician: [] [] [] (Format: DD-MMM-YYYY)

Additional Information:
 Completed series
 Immune
 Blanket waiver(s) requested

Lab Test Date: [] [] [] [] (Format: DD-MMM-YYYY)

Immunization Dates:
Click 'Add Date' to add an immunization date + [Add Date](#)

Hib Haemophilus Influenzae Type B

Given By Panel Physician: [] [] [] (Format: DD-MMM-YYYY)

Additional Information:
 Completed series
 Immune
 Blanket waiver(s) requested

Lab Test Date: [] [] [] [] (Format: DD-MMM-YYYY)

Immunization Dates:
Click 'Add Date' to add an immunization date + [Add Date](#)

Hepatitis A

Given By Panel Physician: [] [] [] (Format: DD-MMM-YYYY)

Additional Information:
 Completed series
 Immune
 Blanket waiver(s) requested

Lab Test Date: [] [] [] [] (Format: DD-MMM-YYYY)

Immunization Dates:
Click 'Add Date' to add an immunization date + [Add Date](#)

Pneumococcal

Given By Panel Physician: [] [] [] (Format: DD-MMM-YYYY)

Additional Information:
 Completed series
 Immune
 Blanket waiver(s) requested

Lab Test Date: [] [] [] [] (Format: DD-MMM-YYYY)

Immunization Dates:
Click 'Add Date' to add an immunization date + [Add Date](#)

< Back: Personal Information Save Next: Immunizations, part 2 >

• 'Lab Test Date' must be a full date.

DS-3025e: Immunization Record Page 1

Displayed for all users. 'Blanket waiver(s) requested' selected for all immunizations, additional fields are displayed.

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COMPLETE REVIEW SIGN

Electronic Vaccination Documentation Worksheet (DS-3025e)

Immunizations for 6 years and younger

To be completed by Panel Physician Only: For refugee applicants, please complete only if reliable vaccination documents are available. Fill in all applicable information.

DT/DTP/DTaP

Specify Type:
- SELECT ONE -

Given By Panel Physician:
(Format: DD-MM-YYYY)

Additional Information:
 Completed series
 Immune
 Blanket waiver(s) requested

To be requested if vaccination not medically appropriate (check suitable box(es)):
 Not Age Appropriate Contra-Indicated
 Insufficient Time Not Routinely Available

Immunization Dates:
Click 'Add Date' to add an immunization date [Add Date](#) [Add Another](#) [Remove](#)

Rotavirus

Given By Panel Physician:
(Format: DD-MM-YYYY)

Additional Information:
 Completed series
 Immune
 Blanket waiver(s) requested

To be requested if vaccination not medically appropriate (check suitable box(es)):
 Not Age Appropriate Contra-Indicated
 Insufficient Time Not Routinely Available

Immunization Dates:
Click 'Add Date' to add an immunization date [Add Date](#)

Hib Haemophilus Influenzae Type B

Given By Panel Physician:
(Format: DD-MM-YYYY)

Additional Information:
 Completed series
 Immune
 Blanket waiver(s) requested

To be requested if vaccination not medically appropriate (check suitable box(es)):
 Not Age Appropriate Contra-Indicated
 Insufficient Time Not Routinely Available

Immunization Dates:
Click 'Add Date' to add an immunization date [Add Date](#)

Hepatitis A

Given By Panel Physician:
(Format: DD-MM-YYYY)

Additional Information:
 Completed series
 Immune
 Blanket waiver(s) requested

To be requested if vaccination not medically appropriate (check suitable box(es)):
 Not Age Appropriate Contra-Indicated
 Insufficient Time Not Routinely Available

Immunization Dates:
Click 'Add Date' to add an immunization date [Add Date](#)

Pneumococcal

Given By Panel Physician:
(Format: DD-MM-YYYY)

Additional Information:
 Completed series
 Immune
 Blanket waiver(s) requested

To be requested if vaccination not medically appropriate (check suitable box(es)):
 Not Age Appropriate Contra-Indicated
 Insufficient Time Not Routinely Available

Immunization Dates:
Click 'Add Date' to add an immunization date [Add Date](#)

[Back: Personal Information](#) [Save](#) [Next: Immunizations, part 2](#)



DS-3025e: Immunization Record Page 2

Displayed for all users. 'Completed series' selected for all immunizations, no additional fields are displayed.

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COMPLETE REVIEW SIGN

Electronic Vaccination Documentation Worksheet (DS-3025e)

Immunizations for 7 years and older

To be completed by Panel Physician Only: For refugee applicants, please complete only if reliable vaccination documents are available. Fill in all applicable information.

Td

- Td
- Tdap

Specify Type:
- SELECT ONE -

Given By Panel Physician: Additional Information:

(Format: DD-MMM-YYYY)

Completed series
 Immune
 Blanket waiver(s) requested

Immunization Dates:
Click 'Add Date' to add an immunization date + Add Date

+ Add Another - Remove

Meningococcal

Given By Panel Physician: Additional Information:

(Format: DD-MMM-YYYY)

Completed series
 Immune
 Blanket waiver(s) requested

Immunization Dates:
Click 'Add Date' to add an immunization date + Add Date

◀ Back: Immunizations, part 1 Save Next: Immunizations, part 3 ▶



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- If a 'Vaccination Type' is selected, at least one vaccination date must be filled in.
- For all applicants other than refugees, all immunizations must have at least one date filled in.
- 'Immunization Dates' can be partial dates.
- 'Given by Panel Physician' must be a full date.

DS-3025e: Immunization Record Page 2

Displayed for all users. 'Immune' selected for all immunizations, additional fields are displayed.

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Electronic Vaccination Documentation Worksheet (DS-3025e)

Immunizations for 7 years and older

To be completed by Panel Physician Only: For refugee applicants, please complete only if reliable vaccination documents are available. Fill in all applicable information.

Td

Specify Type:

Given By Panel Physician: <input type="text"/> <input type="text"/> <input type="text"/> <small>(Format: DD-MMM-YYYY)</small>	Additional Information: <input type="radio"/> Completed series <input checked="" type="radio"/> Immune <div style="border: 1px solid #ccc; padding: 5px; margin-top: 5px;">Lab Test Date: <input type="text"/> <input type="text"/> <input type="text"/> <small>(Format: DD-MMM-YYYY)</small></div> <input type="radio"/> Blanket waiver(s) requested
--	--

Immunization Dates:
Click 'Add Date' to add an immunization date [+ Add Date](#)

[+ Add Another](#) [- Remove](#)

Meningococcal

Given By Panel Physician:

(Format: DD-MMM-YYYY)

	Additional Information: <input type="radio"/> Completed series <input checked="" type="radio"/> Immune <div style="border: 1px solid #ccc; padding: 5px; margin-top: 5px;">Lab Test Date: <input type="text"/> <input type="text"/> <input type="text"/> <small>(Format: DD-MMM-YYYY)</small></div> <input type="radio"/> Blanket waiver(s) requested
--	--

Immunization Dates:
Click 'Add Date' to add an immunization date [+ Add Date](#)

◀ Back: Immunizations, part 1Next: Immunizations, part 3 ▶Save



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DS-3025e: Immunization Record Page 2

Displayed for all users. 'Blanket waiver(s) requested' selected for all immunizations, additional fields are displayed.

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COMPLETEREVIEWSIGN

Electronic Vaccination Documentation Worksheet (DS-3025e)

Immunizations for 7 years and older

To be completed by Panel Physician Only: For refugee applicants, please complete only if reliable vaccination documents are available. Fill in all applicable information.

Td

Specify Type:
- SELECT ONE -

Given By Panel Physician:

(Format: DD-MMM-YYYY)

Additional Information:

Completed series
 Immune
 Blanket waiver(s) requested

To be requested if vaccination not medically appropriate (check suitable box(es)):

Not Age Appropriate Contra-Indicated

Insufficient Time Not Routinely Available

Immunization Dates:

Click 'Add Date' to add an immunization date [+ Add Date](#)

[+ Add Another](#) [- Remove](#)

Meningococcal

Given By Panel Physician:

(Format: DD-MMM-YYYY)

Additional Information:

Completed series
 Immune
 Blanket waiver(s) requested

To be requested if vaccination not medically appropriate (check suitable box(es)):

Not Age Appropriate Contra-Indicated

Insufficient Time Not Routinely Available

Immunization Dates:

Click 'Add Date' to add an immunization date [+ Add Date](#)

◀ Back: Immunizations, part 1 Save Next: Immunizations, part 3 ▶



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DS-3025e: Immunization Record Page 3

Displayed for all users. Answered 'Yes' to 'TST Completed' and 'Completed series' is selected for all immunizations, no additional fields are displayed.

The screenshot shows the 'Electronic Vaccination Documentation Worksheet (DS-3025e)' interface. The page title is 'Immunizations for all ages'. A note states: 'To be completed by Panel Physician Only: For refugee applicants, please complete only if reliable vaccination documents are available. Fill in all applicable information.' The form is divided into sections for different immunizations: TST, Polio OPV/IPV, Hepatitis B, Influenza, and MMR. Each section includes a 'Given By Panel Physician' field (with a date picker), an 'Additional Information' section with radio buttons for 'Completed series', 'Immune', and 'Blanket waiver(s) requested', and an 'Immunization Dates' section with an 'Add Date' button. The 'TST' section has a 'Yes' radio button selected and a 'TST Completed' checkbox. The 'Polio OPV/IPV' section has a dropdown menu for 'Specify Type' with an arrow pointing to a list: '• OPV' and '• IPV'. The 'MMR' section has a dropdown menu for 'Specify Type' with an arrow pointing to a list: '• MMR', '• Measles', '• Mumps', '• Rubella', '• Measles-Rubella', and '• Mumps-Rubella'. At the bottom, there are buttons for 'Back: Immunizations, part 2', 'Save', and 'Next: Results'.

- If a 'Vaccination Type' is selected, at least one vaccination date must be filled in.
- For all applicants other than refugees, all immunizations must have at least one date filled in.
- 'Immunization Dates' can be partial dates.
- 'Given by Panel Physician' must be a full date.

DS-3025e: Immunization Record Page 3

Displayed for all users. Answered 'No' to 'TST Completed' and 'Completed series' is selected for all immunizations except 'Varicella' where 'Varicella history' is selected, no additional fields are displayed.

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COMPLETE REVIEW SIGN

Electronic Vaccination Documentation Worksheet (DS-3025e)

Immunizations for all ages

To be completed by Panel Physician Only: For refugee applicants, please complete only if reliable vaccination documents are available. Fill in all applicable information.

TST

Yes No TST Completed

Polio OPV/IPV

Specify Type:
- SELECT ONE -

Given By Panel Physician: Additional Information:

(Format: DD-MMM-YYYY)

Completed series
 Immune
 Blanket waiver(s) requested

Immunization Dates:

Click 'Add Date' to add an immunization date [Add Date](#)

[Add Another](#) [Remove](#)

Hepatitis B

Given By Panel Physician: Additional Information:

(Format: DD-MMM-YYYY)

Completed series
 Immune
 Blanket waiver(s) requested

Immunization Dates:

Click 'Add Date' to add an immunization date [Add Date](#)

Influenza

Given By Panel Physician: Additional Information:

(Format: DD-MMM-YYYY)

Completed series
 Immune
 Blanket waiver(s) requested

Immunization Dates:

Click 'Add Date' to add an immunization date [Add Date](#)

Varicella

Given By Panel Physician: Additional Information:

(Format: DD-MMM-YYYY)

Completed series
 Varicella history
 Immune
 Blanket waiver(s) requested

Immunization Dates:

Click 'Add Date' to add an immunization date [Add Date](#)

MMR

Specify Type:
- SELECT ONE -

Given By Panel Physician: Additional Information:

(Format: DD-MMM-YYYY)

Completed series
 Immune
 Blanket waiver(s) requested

Immunization Dates:

Click 'Add Date' to add an immunization date [Add Date](#)

[Add Another](#) [Remove](#)

[Back: Immunizations, part 2](#) [Save](#) [Next: Results](#)

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HARRIS

DS-3025e: Immunization Record Page 3

Displayed for all users. 'Immune' selected for all immunizations, additional fields are displayed.

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COMPLETE REVIEW PSR

Electronic Vaccination Documentation Worksheet (DS-3025e)

Immunizations for all ages

To be completed by Panel Physician Only: For refugee applicants, please complete only if reliable vaccination documents are available. Fill in all applicable information.

TST

Yes No
 TST Completed

Polio OPV/IPV

Specify Type:
- SELECT ONE -

Given By Panel Physician:
[] [] []
(Format: DD-MMM-YYYY)

Additional Information:
 Completed series
 Immune
 Blanket waiver(s) requested

Lab Test Date:
[] [] [] []
(Format: DD-MMM-YYYY)

Immunization Dates:
Click 'Add Date' to add an immunization date + Add Date

+ Add Another - Remove

Hepatitis B

Given By Panel Physician:
[] [] []
(Format: DD-MMM-YYYY)

Additional Information:
 Completed series
 Immune
 Blanket waiver(s) requested

Lab Test Date:
[] [] [] []
(Format: DD-MMM-YYYY)

Immunization Dates:
Click 'Add Date' to add an immunization date + Add Date

Influenza

Given By Panel Physician:
[] [] []
(Format: DD-MMM-YYYY)

Additional Information:
 Completed series
 Immune
 Blanket waiver(s) requested

Lab Test Date:
[] [] [] []
(Format: DD-MMM-YYYY)

Immunization Dates:
Click 'Add Date' to add an immunization date + Add Date

Varicella

Given By Panel Physician:
[] [] []
(Format: DD-MMM-YYYY)

Additional Information:
 Completed series
 Varicella history
 Immune
 Blanket waiver(s) requested

Lab Test Date:
[] [] [] []
(Format: DD-MMM-YYYY)

Immunization Dates:
Click 'Add Date' to add an immunization date + Add Date

MMR

Specify Type:
- SELECT ONE -

Given By Panel Physician:
[] [] []
(Format: DD-MMM-YYYY)

Additional Information:
 Completed series
 Immune
 Blanket waiver(s) requested

Lab Test Date:
[] [] [] []
(Format: DD-MMM-YYYY)

Immunization Dates:
Click 'Add Date' to add an immunization date + Add Date

+ Add Another - Remove

< Back: Immunizations, part 2 Save Next Results >

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• 'Lab Test Date' must be a full date.

DS-3025e: Immunization Record Page 3

Displayed for all users. 'Blanket waiver(s) requested' selected for all immunizations, additional fields are displayed.

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COMPLETE REVIEW SUB

Electronic Vaccination Documentation Worksheet (DS-3025e)

Immunizations for all ages

To be completed by Panel Physician Only: For refugee applicants, please complete only if reliable vaccination documents are available. Fill in all applicable information.

TST

Yes No TST Completed

Polio OPV/IPV

Specify Type:
- SELECT ONE -

Gives By Panel Physician:
[] [] []
(Format: DD-MMMM-YYYY)

Additional Information:
 Completed series
 Immune
 Blanket waiver(s) requested

To be requested if vaccination not medically appropriate (check suitable box(es)):
 Not Age Appropriate Contra-Indicated
 Insufficient Time Not Routinely Available

Immunization Dates:
Click 'Add Date' to add an immunization date + Add Date + Add Another - Remove

Hepatitis B

Gives By Panel Physician:
[] [] []
(Format: DD-MMMM-YYYY)

Additional Information:
 Completed series
 Immune
 Blanket waiver(s) requested

To be requested if vaccination not medically appropriate (check suitable box(es)):
 Not Age Appropriate Contra-Indicated
 Insufficient Time Not Routinely Available

Immunization Dates:
Click 'Add Date' to add an immunization date + Add Date

Influenza

Gives By Panel Physician:
[] [] []
(Format: DD-MMMM-YYYY)

Additional Information:
 Completed series
 Immune
 Blanket waiver(s) requested

To be requested if vaccination not medically appropriate (check suitable box(es)):
 Not Age Appropriate Contra-Indicated
 Insufficient Time Not Routinely Available
 Not Fall (Flu) Season

Immunization Dates:
Click 'Add Date' to add an immunization date + Add Date

Varicella

Gives By Panel Physician:
[] [] []
(Format: DD-MMMM-YYYY)

Additional Information:
 Completed series
 Varicella history
 Immune
 Blanket waiver(s) requested

To be requested if vaccination not medically appropriate (check suitable box(es)):
 Not Age Appropriate Contra-Indicated
 Insufficient Time Not Routinely Available

Immunization Dates:
Click 'Add Date' to add an immunization date + Add Date

MMR2

Specify Type:
- SELECT ONE -

Gives By Panel Physician:
[] [] []
(Format: DD-MMMM-YYYY)

Additional Information:
 Completed series
 Immune
 Blanket waiver(s) requested

To be requested if vaccination not medically appropriate (check suitable box(es)):
 Not Age Appropriate Contra-Indicated
 Insufficient Time Not Routinely Available

Immunization Dates:
Click 'Add Date' to add an immunization date + Add Date + Add Another - Remove

4 Back: Immunizations, part 2 Save Next: Results

DS-3025e: Results Page

Displayed for all users.

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COMPLETE REVIEW SIGN

Electronic Vaccination Documentation Worksheet (DS-3025e)

Results

Required for U.S. immigrant visa applicants. Not required for refugee applicants.

To be completed by Panel Physician only: For refugee applicants, please complete only if reliable vaccination documents are available.

Select one of the three options below.

- Vaccine history incomplete
 - Applicant may be eligible for blanket waiver(s) because vaccination(s) not medically appropriate
 - Applicant will request an individual waiver based on religious or moral convictions
- Vaccine history complete for each vaccine, all requirements met
- Applicant does not meet vaccination requirements for one or more vaccines and no waiver is requested
- None of the above

◀ Back: Immunizations Save Next: Review ▶

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- One of the fields must be selected.
- If 'Vaccine history incomplete' is selected, one of the additionally displayed fields must be selected.

DS-3025e: Signature Page

Displayed for all users. Only users logged in as a Panel Physician can sign the page.

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COMPLETE REVIEW SIGN

Electronic Vaccination Documentation Worksheet (DS-3025e)

Sign and Certify

E-Sign and Certification

Help: Navigation Buttons

Click on the buttons above to access previously entered data.

Read the following information carefully before dating, and electronically signing the form.

This form is now ready to be signed. By clicking "Sign Form," you are electronically signing the form. As a selected Panel Physician, you are required to electronically sign the form yourself. Your electronic signature certifies that you have performed this medical examination in accordance with the Centers for Disease Control and Prevention's (CDC) Technical Instructions and their updates, read and understood the questions on this form, and that your answers are true and correct to the best of your knowledge and belief.

Tuesday, October 26, 2010 - 11:27:49 AM EST

E-Signature

Enter your password:

Enter the code below as shown:

Y4Mw9

Click the button below to electronically sign the form:

Sign Form



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DS-3025e: Signature Page

Displayed after the panel physician has signed the 3025e form.

The screenshot shows the 'SIGN' step of the 'Electronic Vaccination Documentation Worksheet (DS-3025e)' process. The page header includes the U.S. Department of State logo and navigation links (Home, Contact Us, Help, Sign Out). The main navigation bar has 'COMPLETE', 'REVIEW', and 'SIGN' tabs. A breadcrumb trail shows the current step: 'Electronic Vaccination Documentation Worksheet (DS-3025e)'. A sidebar on the left contains an 'E-Sign and Certification' button and a 'Help: Navigation Buttons' section with instructions to click on buttons above to access previously entered data. The main content area displays a success message: 'You have successfully signed the form.' Below this message is a button labeled 'Continue' and a prompt to 'Click 'Continue' to return to Summary page.' At the bottom of the page, there is a footer with a 'C' logo and text stating the site is managed by the Bureau of Consular Affairs, U.S. Department of State, with links to Copyright Information, Disclaimers, and Paperwork Reduction Act and Confidentiality Statement.

DS-3026e: Getting Started Page

Displayed for all users.

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CONSULAR ELECTRONIC APPLICATION CENTER

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COMPLETE REVIEW SIGN

Medical History And Physical Examination Worksheet (DS-3026e)

Getting Started

NOTE: If there is no activity for 20 minutes or more in the process of completing this online application, your session will expire and some data might be lost. Data entered will be saved as you advance through the application by clicking the Next button. However, data on the current page will be lost if there is no activity for 20 minutes.

Click the button below to begin the Medical History And Physical Examination Worksheet (DS-3026e)

The following instructions contain important information about completing this form. Please read all instructions carefully.

Instructions for completing the Medical History And Physical Examination Worksheet (DS-3026e):

These forms can only be completed by panel physicians appointed by the Department of State. Please abide by the following guidelines in completing the forms:

1. Enter the information requested into the appropriate spaces in each window. Please answer all questions. Your answers must be in English and must use English characters, except when you are asked to provide your full name in your native alphabet. Letters like ñ, é, ú, ç are not recognized by the system. Please enter names like Muñoz and Semónin as Munoz and Semonin, unless otherwise asked.
2. Review the information you entered for accuracy.
3. All exams must be performed in accordance with the Centers for Disease Control and Prevention's (CDC) Technical Instructions and their updates.

Begin Resume Medical Form Process:

Continue


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- The user selects the 'Continue' button.

DS-3026e: Personal Information Page

Displayed for all users.

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COMPLETE REVIEW SIGN

Medical History And Physical Examination Worksheet (DS-3026e)

OMB CONTROL NUMBER: 1405-0113
FORM NUMBER: DS-3026e
EXPIRATION DATE: 04/30/2012
ESTIMATED BURDEN: 35 minutes

- Getting Started
- Personal**
- Medical History
- Physical Exam
- Additional Testing
- Follow-Up
- Remarks

Help: Navigation Buttons

Click on the buttons above to access previously entered data.


Personal Information

Case Number <input type="text" value="CDJ2005607643"/> <input type="checkbox"/> Did Not Provide	A Number <input type="text"/> <input type="checkbox"/> Did Not Provide	
Surname <input type="text" value="SAMPLE"/>	Given Name <input type="text" value="MARIA"/>	
Sex <input checked="" type="radio"/> Male <input type="radio"/> Female	Date of Birth <input type="text" value="25"/> <input type="text" value="AUG"/> <input type="text" value="1974"/> <small>(Format: DD-MMM-YYYY)</small>	Exam Date <input type="text"/> <input type="text"/> <input type="text"/> <small>(Format: DD-MMM-YYYY)</small>
Passport		
Country/Authority That Issued Passport <input type="text" value="- SELECT ONE -"/>	Passport Number <input type="text"/> <input type="checkbox"/> Did Not Provide	

PAPERWORK REDUCTION ACT: Public reporting burden for this collection of information is estimated to average 35 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/GIS/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 State 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.

◀ Back: Getting Started Save Next: Medical History ▶



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- The following fields are required: 'Surname', 'Given Name', 'Sex', 'Exam Date' 'Date of Birth', 'Passport Number' or 'Did Not Provide', 'A Number' or 'Did Not Provide', 'Case Number' or 'Did Not Provide'.
- 'Date of Birth' can be a partial date for refugee applicants; all other applicant types must have a full date.
- 'Exam Date' must be a full date.

DS-3026e: Medical History Page

Displayed for all users. Answered all questions 'No', no additional fields are enabled.

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CONSULAR ELECTRONIC APPLICATION CENTER

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COMPLETE REVIEW EDIT

Medical History And Physical Examination Worksheet (DS-3026e)

Medical History

Indicate conditions requiring medication or other treatment after resettlement and give details in the Remarks section.
NOTE: The following history has been reported, has not been verified by a physician, and should not be deemed medically definitive.

General

No Yes
 Illness or injury requiring hospitalization (including psychiatric)

Cardiology

No Yes
 Heart Disease
 Hypertension (high blood pressure)
 Cardiac arrhythmia

Pulmonology

No Yes
 History of tobacco use
Yes No
 Current use

Asthma
 Chronic obstructive pulmonary disease (emphysema)
 History of tuberculosis
Yes No
 Treated
 Current TB symptoms

Neurology and Psychiatry

No Yes
 History of stroke, with current impairment
 Seizure disorder
 Major impairment in learning, intelligence, self care, memory, or communication
 Major mental disorder (including major depression, bipolar disorder, schizophrenia, mental retardation)
 Use of drugs other than those required for medical reasons
 Addition or abuse of specific substance (drug)
 Other substance-related disorders (including alcohol addiction or abuse)
 Ever taken action to end your life
 Ever caused SERIOUS injury to others, caused MAJOR property damage or had trouble with the law because of medical condition, mental disorder, or influence of alcohol or drugs

Obstetrics and Sexually Transmitted Diseases

No Yes
 Pregnancy
Last menstrual period date:
[Month] [Day] [Year]
Estimated date of delivery:
[Month] [Day] [Year]

Sexually transmitted diseases
Specify:
[Text Field]

Endocrinology and Hematology

No Yes
 Diabetes mellitus
Type: [SELECT ONE]
Since: [Month] [Year]

Thyroid disease
 History of malaria

Others

No Yes
 Malignancy
Specify:
[Text Field]

Chronic renal disease
 Chronic hepatitis or other chronic liver disease
 Hansen's Disease
Type: Multibacillary Paucibacillary
Yes No
 Treated

Visible disabilities (including loss of arms or legs)
Specify:
[Text Field]

Other requiring treatment
Specify:
[Text Field]

Back Personal Information Save Next: Physical Examination

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- The following fields are required: 'Yes' or 'No' for every field.
- 'Last menstrual period date' can be a partial date.

DS-3026e: Medical History Page, Top

Displayed for all users. Answered all questions 'No', no additional fields are enabled.

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COMPLETEREVIEWSIGN

Medical History And Physical Examination Worksheet (DS-3026e)

Medical History

Indicate conditions requiring medication or other treatment after resettlement and give details in the Remarks section.
NOTE: The following history has been reported, has not been verified by a physician, and should not be deemed medically definitive.

General

No Yes
 Illness or injury requiring hospitalization (*including psychiatric*)

Cardiology

No Yes
 Heart Disease
 Hypertension (*high blood pressure*)
 Cardiac arrhythmia

Pulmonology

No Yes
 History of tobacco use

Yes No

Current use

 Asthma
 Chronic obstructive pulmonary disease (*emphysema*)
 History of tuberculosis

Yes No

Treated
 Current TB symptoms

- ✓ Getting Started
- Personal
- Medical History**
- Physical Exam
- Additional Testing
- Follow-Up
- Remarks

[Help: Navigation Buttons](#)

Click on the buttons above to access previously entered data.

CEAC Medical OMB Package

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DS-3026e: Medical History Page, Middle

Displayed for all users. Answered all questions 'No', no additional fields are enabled.

Neurology and Psychiatry

No Yes

- History of stroke, with current impairment
- Seizure disorder
- Major impairment in learning, intelligence, self care, memory, or communication
- Major mental disorder (including major depression, bipolar disorder, schizophrenia, mental retardation)
- Use of drugs other than those required for medical reasons
- Addiction or abuse of specific substance ⓘ (drug)
- Other substance-related disorders (including alcohol addiction or abuse)
- Ever taken action to end your life
- Ever caused SERIOUS injury to others, caused MAJOR property damage or had trouble with the law because of medical condition, mental disorder, or influence of alcohol or drugs

Obstetrics and Sexually Transmitted Diseases

No Yes

Pregnancy

Last menstrual period date:

Estimated date of delivery:

Sexually transmitted diseases

Specify:

Endocrinology and Hematology

No Yes

Diabetes mellitus

Type:

Since:

Thyroid disease

History of malaria

DS-3026e: Medical History Page, Bottom

Displayed for all users. Answered all questions 'No', no additional fields are enabled.

Others

No Yes

Malignancy
Specify:

Chronic renal disease

Chronic hepatitis or other chronic liver disease

Hansen's Disease
Type: Multibacillary Paucibacillary
Yes No
 Treated

Visible disabilities (including loss of arms or legs)
Specify:

Other requiring treatment
Specify:

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DS-3026e: Medical History Page

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Medical History And Physical Examination Worksheet (DS-3026e)

Medical History

Indicate conditions requiring medication or other treatment after resettlement and give details in the Remarks section.
NOTE: The following history has been reported, has not been verified by a physician, and should not be deemed medically definitive.

General

No Yes
 Stress or injury requiring hospitalization (including psychiatric)

Cardiology

No Yes
 Heart Disease
 Hypertension (high blood pressure)
 Cardiac arrhythmia

Pulmonology

No Yes
 History of tobacco use
Yes No
 Current use

Asthma
 Chronic obstructive pulmonary disease (emphysema)
 History of tuberculosis
Yes No
 Treated
 Current TB symptoms

Neurology and Psychiatry

No Yes
 History of stroke, with current impairment
 Seizure disorder
 Major impairment in learning, intelligence, self care, memory, or communication
 Major mental disorder (including major depression, bipolar disorder, schizophrenia, mental retardation)
 Use of drugs other than those required for medical reasons
 Addiction or abuse of specific substance (drug)
 Other substance-related disorders (including alcohol addiction or abuse)
 Ever taken action to end your life
 Ever caused SERIOUS injury to others, caused MAJOR property damage or had trouble with the law because of medical condition, mental disorder, or influence of alcohol or drugs

Obstetrics and Sexually Transmitted Diseases

No Yes
 Pregnancy
Last menstrual period date: [] [] [] [] [] []
Estimated date of delivery: [] [] [] [] [] []

Sexually transmitted diseases
Specify: [] [] [] [] [] []

Endocrinology and Hematology

No Yes
 Diabetes mellitus
Type: [SELECT ONE]
Since: [] [] [] [] [] [] (Format: MM-YY)

Thyroid disease
 History of malaria

Others

No Yes
 Malignancy
Specify: [] [] [] [] [] []

Chronic renal disease
 Chronic hepatitis or other chronic liver disease
 Hansen's Disease
Type: Multibacillary Paucibacillary
Yes No
 Treated

Visible disabilities (including loss of arms or legs)
Specify: [] [] [] [] [] []

Other requiring treatment
Specify: [] [] [] [] [] []

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- If 'Yes' for 'History of Tuberculosis', then 'Treated' or 'Current TB symptoms' must be selected.
- If 'Yes' for 'Pregnancy', then 'Last menstrual period date' must be answered.
- If 'Yes' for 'Hansen's Disease', then 'Multibacillary' or 'Paucibacillary' must be selected.

DS-3026e: Medical History Page, Top

Displayed for all users. Answered all questions 'Yes', additional fields are enabled.

Medical History And Physical Examination Worksheet (DS-3026e)

Medical History

Indicate conditions requiring medication or other treatment after resettlement and give details in the Remarks section.

NOTE: The following history has been reported, has not been verified by a physician, and should not be deemed medically definitive.

General

No Yes

Illness or injury requiring hospitalization (including psychiatric)

Cardiology

No Yes

Heart Disease

Hypertension (high blood pressure)

Cardiac arrhythmia

Pulmonology

No Yes

History of tobacco use

Yes No

Current use

Asthma

Chronic obstructive pulmonary disease (emphysema)

History of tuberculosis

Yes No

Treated

Current TB symptoms

Getting Started

Personal

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Physical Exam

Additional Testing

Follow-Up

Remarks

Help: Navigation Buttons

Click on the buttons above to access previously entered data.

DS-3026e: Medical History Page, Middle

Displayed for all users. Answered all questions 'Yes', additional fields are enabled.

Neurology and Psychiatry

No Yes

- History of stroke, with current impairment
- Seizure disorder
- Major impairment in learning, intelligence, self care, memory, or communication
- Major mental disorder (including major depression, bipolar disorder, schizophrenia, mental retardation)
- Use of drugs other than those required for medical reasons
- Addiction or abuse of specific substance ⓘ (drug)
- Other substance-related disorders (including alcohol addiction or abuse)
- Ever taken action to end your life
- Ever caused SERIOUS injury to others, caused MAJOR property damage or had trouble with the law because of medical condition, mental disorder, or influence of alcohol or drugs

Obstetrics and Sexually Transmitted Diseases

No Yes

Pregnancy

Last menstrual period date:

Estimated date of delivery:

Sexually transmitted diseases

Specify:

Endocrinology and Hematology

No Yes

Diabetes mellitus

Type:

Since:

(Format: MMM-YYYY)

- Thyroid disease
- History of malaria

DS-3026e: Medical History Page, Bottom

Displayed for all users. Answered all questions 'Yes', additional fields are enabled.

Others

No Yes

Malignancy
Specify:

Chronic renal disease

Chronic hepatitis or other chronic liver disease

Hansen's Disease
Type: Multibacillary Paucibacillary
Yes No
 Treated

Visible disabilities (including loss of arms or legs)
Specify:

Other requiring treatment
Specify:

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DS-3026e: Physical Examination Page

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COMPLETE

REVIEW

SIGN

Medical History And Physical Examination Worksheet (DS-3026e)

Physical Examination

Indicate findings and give details on the Remarks page.

Getting Started

Personal

Medical History

Physical Exam

Additional Testing

Follow-Up

Remarks

No Yes
 Applicant appears to be providing unreliable or false information
Specify:

Height . cm

Weight . kg

Heart rate /min

Respiratory rate /min

Blood pressure / (mmHg)

Visual Acuity at 20 feet
Uncorrected L 20 / R 20 / Corrected L 20 / R 20 /

Notes

General appearance and nutritional status	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Hearing and ears	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Eyes	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Nose, mouth, and throat (include dental)	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Heart (S1, S2, murmur, rub)	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Breast	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Lungs	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Abdomen (including liver, spleen)	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
If pregnant, fundal height: <input type="text"/> cm			
Genitalia (including circumcision, infection(s))	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Inguinal region (including adenopathy)	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Extremities (including pulses, edema)	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Musculoskeletal system (including gait)	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Skin (including hypopigmentation, anesthesia, findings consistent with self-inflicted injury or injections)	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Lymph nodes	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Nervous system (including nerve enlargement)	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Mental status (including mood, intelligence, perception, thought processes, and behavior during examination)	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done

← Back: Medical History Save Next: Additional Testing →



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• The following fields are required: 'Normal', 'Abnormal', or 'Not done' must be selected.

DS-3026e: Physical Examination Page

Displayed for all users. Answered 'Yes' to 'Applicant appears...', the 'Specify' field is enabled.

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COMPLETE REVIEW SIGN

Medical History And Physical Examination Worksheet (DS-3026e)

Physical Examination

Indicate findings and give details on the Remarks page.

No Yes
 Applicant appears to be providing unreliable or false information
Specify:

Height . cm Weight . kg

Heart rate /min Respiratory rate /min Blood pressure / (mmHg)

Visual Acuity at 20 feet
Uncorrected Corrected
L 20 / R 20 / L 20 / R 20 /

Notes

General appearance and nutritional status	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Hearing and ears	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Eyes	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Nose, mouth, and throat (include dental)	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Heart (S1, S2, murmur, rub)	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Breast	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Lungs	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Abdomen (including liver, spleen)	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
If pregnant, fundal height: <input type="text"/> cm			
Genitalia (including circumcision, infection(s))	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Inguinal region (including adenopathy)	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Extremities (including pulses, edema)	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Musculoskeletal system (including gait)	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Skin (including hypopigmentation, anesthesia, findings consistent with self-inflicted injury or injections)	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Lymph nodes	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Nervous system (including nerve enlargement)	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Mental status (including mood, intelligence, perception, thought processes, and behavior during examination)	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done

◀ Back: Medical History Save Next: Additional Testing ▶



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• The following fields are required: 'Normal', 'Abnormal', or 'Not done' must be selected.

DS-3026e: Physical Examination Page, Top

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COMPLETEREVIEWSIGN

Medical History And Physical Examination Worksheet (DS-3026e)

Physical Examination

Indicate findings and give details on the Remarks page.

No Yes Applicant appears to be providing unreliable or false information
Specify:

Height
 . cm

Weight
 . kg

Heart rate
 /min

Respiratory rate
 /min

Blood pressure
 / (mmHg)

Visual Acuity at 20 feet

Uncorrected
L 20 / R 20 /

Corrected
L 20 / R 20 /

Notes

Help: Navigation Buttons

Click on the buttons above to access previously entered data.

- Getting Started
- Personal
- Medical History
- Physical Exam**
- Additional Testing
- Follow-Up
- Remarks

DS-3026e: Physical Examination Page, Bottom

Displayed for all users.

General appearance and nutritional status	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Hearing and ears	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Eyes	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Nose, mouth, and throat (include dental)	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Heart (S1, S2, murmur, rub)	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Breast	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Lungs	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Abdomen (including liver, spleen)	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
If pregnant, fundal height: <input type="text"/> cm			
Genitalia (including circumcision, infection(s))	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Inguinal region (including adenopathy)	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Extremities (including pulses, edema)	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Musculoskeletal system (including gait)	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Skin (including hypopigmentation, anesthesia, findings consistent with self-inflicted injury or injections)	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Lymph nodes	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Nervous system (including nerve enlargement)	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done
Mental status (including mood, intelligence, perception, thought processes, and behavior during examination)	<input type="radio"/> Normal	<input type="radio"/> Abnormal	<input type="radio"/> Not done

◀ Back: Medical History

Save

Next: Additional Testing ▶



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DS-3026e: Additional Testing Needed Prior to Approving Medical Clearance Page

Displayed for all users. Answered all questions 'No', no additional fields are enabled.

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COMPLETE REVIEW SIGN

Medical History And Physical Examination Worksheet (DS-3026e)

Additional Testing Needed Prior to Approving Medical Clearance

Check all boxes that apply.

No Yes
 Physical examination or laboratory results contradict medical history

No Yes
 Referral prior to departure
Provide results:

◀ Back: Physical Examination Save Next: Follow-Up ▶


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- The following fields are required: 'Yes' or 'No' for every field.

DS-3026e: Additional Testing Needed Prior to Approving Medical Clearance Page

Displayed for all users. Answered all questions 'Yes', the 'Provide results' field is enabled.

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COMPLETEREVIEWSIGN

Medical History And Physical Examination Worksheet (DS-3026e)

Additional Testing Needed Prior to Approving Medical Clearance

Check all boxes that apply.

No Yes


Physical examination or laboratory results contradict medical history

No Yes

Referral prior to departure

Provide results:


◀ Back: Physical Examination Save Next: Follow-Up ▶

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DS-3026e: Follow-up Needed After Arrival Page

Displayed for all users. Answered all questions 'No', no additional fields are enabled.

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Medical History And Physical Examination Worksheet (DS-3026e)

Follow-up Needed After Arrival

Check all boxes that apply.

Getting Started
Personal
Medical History
Physical Exam
Additional Testing
Follow-Up
Remarks

Help: Navigation Buttons
Click on the buttons above to access previously entered data.

No Yes
 Follow-up needed after arrival
 Within 1 month Within 6 months

No Yes
 Continuing medication
List type, dose, and frequency
(Exception: For TB medications, use the Tuberculosis Treatment Regimen page from the DS-2053e or DS-2054e form)

No Yes
 Continuing other treatment
Specify:

◀ Back: Additional Testing Save Next: Remarks ▶



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- The following fields are required: 'Yes' or 'No' for every field.

DS-3026e: Follow-up Needed After Arrival Page

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Medical History And Physical Examination Worksheet (DS-3026e)

Follow-up Needed After Arrival

Check all boxes that apply.

Follow-up needed after arrival

No Yes

Within 1 month Within 6 months

Continuing medication
List type, dose, and frequency
(Exception: For TB medications, use the Tuberculosis Treatment Regimen page from the DS-2053e or DS-2054e form)

No Yes

Continuing other treatment
Specify:

◀ Back: Additional Testing Save Next: Remarks ▶



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- If 'Yes' is selected for 'Follow-up needed after arrival', then a time period must also be selected. Only one time period may be selected.

DS-3026e: Remarks Page

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Medical History And Physical Examination Worksheet (DS-3026e)

- Getting Started
- Personal
- Medical History
- Physical Exam
- Additional Testing
- Follow-Up
- Remarks

Help: Navigation Buttons

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Remarks

Describe any abnormal history, abnormal findings, and resulting interventions.

Remarks **Optional*

◀ Back: Follow-Up

Save

Next: Review ▶

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DS-3026e: Signature Page


Displayed for all users. Only users logged in as a Panel Physician can sign the page.

The screenshot shows the 'SIGN' step of the DS-3026e application process. At the top, there is a navigation bar with 'Home', 'Contact Us', 'Help', and 'Sign Out' links. Below this is the U.S. Department of State logo and the text 'U.S. DEPARTMENT of STATE CONSULAR ELECTRONIC APPLICATION CENTER'. A progress bar indicates the current step is 'SIGN'. The main heading is 'Medical History And Physical Examination Worksheet (DS-3026e) Sign and Certify'. On the left, there is a sidebar with 'E-Sign and Certification' and 'Help: Navigation Buttons'. The main content area contains instructions: 'Read the following information carefully before dating, and electronically signing the form.' It states that the form is ready for signing and that the user, as a Panel Physician, must certify that they have performed the medical examination in accordance with CDC Technical Instructions. A timestamp shows 'Tuesday, October 26, 2010 - 11:24:27 AM EST'. There are input fields for 'E-Signature', 'Enter your password', and 'Enter the code below as shown:'. A large, semi-transparent 'SAMPLE' watermark is overlaid across the center. Below the input fields, there is a button labeled 'Sign Form' and a note: 'Click the button below to electronically sign the form:'. At the bottom, there is a footer with a 'C' logo and text: 'This site is managed by the Bureau of Consular Affairs, U.S. Department of State. External links to other Internet sites should not be construed as an endorsement of the views contained therein. Copyright Information | Disclaimers | Paperwork Reduction Act and Confidentiality Statement'.

DS-3026e: Signature Page

Displayed after the panel physician has signed the 3026e form.

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COMPLETE REVIEW SIGN

Medical History And Physical Examination Worksheet (DS-3026e) Unsign


Sign and Certify

You have successfully signed the form.

Click 'Continue' to return to Summary page.

Help: Navigation Buttons

Click on the buttons above to access previously entered data.



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