



U. S. Department of State
**MEDICAL EXAMINATION FOR
 IMMIGRANT OR REFUGEE APPLICANT**
 For use with TB Technical Instructions 2007 and the DS-3030

OMB No. 1405-0113
 EXPIRATION DATE: 07/31/2013
 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 of Medical Exam (Date of TB physical exam or date of lab report of final TB culture results, if cultures performed) (mm-dd-yyyy) _____

Date Exam Expires (3 months if Class A TB, or Class B1 TB, otherwise 6 months) (mm-dd-yyyy) _____

Date (mm-dd-yyyy) of Prior Exam, if any _____ Exam Place (City/Country) _____ / _____

Panel Physician _____ Radiology Services _____

Screening Site _____ Lab (Name for syphilis/TB) _____ / _____

(1) Classification (Check all boxes that apply):

No apparent defect, disease, or disability (See Worksheets DS-3025, DS-3026, and DS-3030)

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"/> Hansen's disease, untreated multibacillary |
| <input type="checkbox"/> Syphilis, untreated | <input type="checkbox"/> Addiction or abuse of specific* substance |
| <input type="checkbox"/> Chancroid, 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"/> Gonorrhea, untreated | |
| <input type="checkbox"/> Granuloma inguinale, untreated | *amphetamines, cannabis, cocaine, hallucinogens, opioids, phencyclidines, sedative-hypnotics, and anxiolytics |
| <input type="checkbox"/> Lymphogranuloma venereum, untreated | |

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

- | | |
|--|---|
| <input type="checkbox"/> Syphilis (with residual defect), treated within the last year | <input type="checkbox"/> Hansen's disease, treated multibacillary
Treatment: <input type="checkbox"/> Partial <input type="checkbox"/> Completed |
| <input type="checkbox"/> Current pregnancy, number of weeks pregnant _____ | <input type="checkbox"/> Hansen's disease, paucibacillary
Treatment: <input type="checkbox"/> None <input type="checkbox"/> Partial <input type="checkbox"/> Completed |
| <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"/> Sustained, full remission of addiction or abuse of specific* substances |
- *amphetamines, cannabis, cocaine, hallucinogens, opioids, phencyclidines, sedative-hypnotics, and anxiolytics

Class B1 TB, Pulmonary

- No treatment
- Completed treatment (Check all that apply and attach all laboratory and DOT documents)
- | | |
|--|---|
| <input type="checkbox"/> By panel physician | <input type="checkbox"/> By non-panel physician |
| <input type="checkbox"/> Initial smear positive | <input type="checkbox"/> Initial culture positive |
| <input type="checkbox"/> Pre-treatment culture and DST results performed/available | <input type="checkbox"/> Pre-treatment culture and/or DST results not performed/available |

Class B1 TB, Extrapulmonary

Anatomic Site of Disease _____

- No treatment
- Current treatment
- Completed treatment

Class B2 TB, LTBI Evaluation

- Test for TB infection positive: TST _____ mm; IGRA positive Result _____ TST or IGRA Conversion
- No LTBI treatment
- Current LTBI treatment (Indicate medications in Part 4 of DS-2054 form)
- Completed LTBI treatment (Indicate medications in Part 4 of DS-2054 form)

Class B Tuberculosis - Continued

Class B3 TB, Contact Evaluation

TST _____ mm IGRA negative IGRA positive IGRA Result _____

No preventive treatment

Current preventive treatment (*Indicate medications in Part 4 of DS-2054 form*)

Completed preventive treatment (*Indicate medications in Part 4 of DS-2054 form*)

Source Case: Name _____

Alien Number _____

Relationship to Contact _____

Date Contact Ended (*mm-dd-yyyy*) _____

Type of Source Case TB (*Mark only one and ATTACH DST RESULTS*)

Pansusceptible TB

MDR TB (*resistant to at least INH and rifampin*)

Drug-resistant TB other than MDR TB

Culture negative

Culture results not available

Class B 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 (<i>mm-dd-yyyy</i>)	Negative	Positive	Titer 1	Notes
Screening						
Confirmatory						

Treated Yes No If treated, therapy: Benzathine penicillin, 2.4 MU IM Other (*therapy, dose*): _____ Date(s) treatment given (*mm-dd-yyyy*) (*3 doses for penicillin*) _____

Test for Cell-Mediated Immunity to TB (*Required for all applicants 2 through 14 years of age; perform one type only*)

TST
Date Applied (*mm-dd-yyyy*) _____ Result (*mm*) _____

IGRA
Name of IGRA Test _____ Date Drawn (*mm-dd-yyyy*) _____
Nil Value (IU/ml or number of cells) _____ TB Response (*TB- nil IU/ml or number of cells**) _____

IGRA Interpretation: Positive Negative Indeterminate, Borderline, or Equivocal

* For T-Spot, TB Response number of cells = Higher of Panel A or Panel B minus nil value

(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>(e.g., 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 CONFIDENTIALITY STATEMENTS

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 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.