

TOOL 6

Completing Medical Examination Forms for US-Bound Immigrant or Refugee Applications

Must select ONE of these classifications

(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)
 TB, active, (Medical Class A, from Chest X-ray Worksheet) Hansen's disease, untreated, multibacillary
 Syphilis, untreated Any physical or mental disorder (including other substance-related disorder with harmful behavior or history of such behavior likely to recur)
 Chancroid, untreated *amphetamine, cannabis, cocaine, hallucinogens, opioids, phencyclidines, sedative-hypnotics, and anxiolytics
 Gonorrhea, untreated *amphetamine, cannabis, cocaine, hallucinogens, opioids, phencyclidines, sedative-hypnotics, and anxiolytics
 Trachoma, untreated *amphetamine, cannabis, cocaine, hallucinogens, opioids, phencyclidines, sedative-hypnotics, and anxiolytics
 Lymphogranuloma venereum, untreated
Class B Conditions (From Past Medical History and Physical Examination Worksheets)
 Syphilis (with residual defect, treated within the last year) Hansen's disease, treated, multibacillary
 Current pregnancy, number of weeks pregnant _____ Hansen's disease, paucibacillary
 Any physical or mental disorder (including addition or abuse of specific substance but including other substance-related disorder without harmful behavior or history of such behavior likely to recur) Sustained, full remission of addition or abuse of specific substance
Class B1 TB, Pulmonary
 No treatment By panel physician By non-panel physician
 Initial sputum positive Initial culture positive
 Pre-treatment culture and DST results performed/available 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)

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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 Hot done
Test Name Date(s) Run (mm-dd-yyyy) Negative Positive Titer 1 Notes
Confirmatory
Yes RPR Venereal Disease Research Laboratory (VDRL) Treponema pallidum (TP) Other (specify) _____
Date(s) treatment given (mm-dd-yyyy) (2 doses for penicillin)
Treat 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 Done (mm-dd-yyyy) _____
NI Value (3NI or number of wells) _____ TB Response (TB or 3NI or number of wells) _____
IGRA Interpretation: Positive Negative Indeterminate, Borderline, or Equivocal
* For T-Spot, TB Response number of wells = Higher of Panel A or Panel B minus n1 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) _____

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This section must be filled out COMPLETELY

OMB No. 1432-0113
EXPIRATION DATE: 08/31/2014
ESTIMATED BURDEN: 10 minutes
(See Page 2 - Back of Form)

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

Photo _____

Name (Last, First, MI) _____ Sex: M F
Birth Date (mm-dd-yyyy) _____
Birthplace (City/Country) _____
Present Country of Residence _____ Prior Country _____
U.S. Consul (City/Country) _____
Passport Number _____ Alien (Case) Number _____ Can be left blank if unknown

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 _____ Name of radiology facility _____
Screening Site _____ Lab (Name for syphilis/TB) _____ Name of syphilis lab _____ Name of TB lab _____

Document treatment information regarding Hansen's disease, Syphilis, and any Physical or Mental Disorders

Class B Conditions (From Past Medical History and Physical Examination Worksheets)
 Syphilis (with residual defect, treated within the last year) Hansen's disease, treated multibacillary
Treatment: Partial Completed
 Current pregnancy, number of weeks pregnant _____ Hansen's disease, paucibacillary
Treatment: None Partial Completed
 Any physical or mental disorder (including addition or abuse of specific substance but including other substance-related disorder) without harmful behavior or history of such behavior unlikely to recur Sustained, full remission of addition or abuse of specific substance
*amphetamine, cannabis, cocaine, hallucinogens, opioids, phencyclidines, sedative-hypnotics, and anxiolytics

Class B1 TB, Pulmonary
 No treatment By panel physician By non-panel physician
 Initial sputum positive Initial culture positive
 Pre-treatment culture and DST results performed/available 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)

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Select B1 classification if applicant had to provide sputum samples

Select B2 classification if applicant had a positive skin test or IGRA

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)
This section should include conditions that are significant departures from normal such as diabetes, hypertension, and heart disease.

Select B3 classification if applicant had previous exposure to a confirmed TB case during infectious period



Completing Medical Examination Forms for US-Bound Immigrant or Refugee Applications

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 _____

Date Contact Done: (mm-dd-yyyy) _____

Relationship to Contact _____

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

Paratubercle 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 worksheet) _____

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

Syphilis: Not done

Test Name	Date(s) Run (mm-dd-yyyy)	Negative	Positive	Titer 1	Notes
Screening					
Confirmatory					

Antisiphilic therapy: Yes No

Benathine penicillin, 2.4 MU IM _____ Date(s) treatment given (mm-dd-yyyy) (3 doses for penicillin)

Other (therapy, dose) _____

For T-spot, TB Response number of cells = higher of Panel A or Panel B minus nil value

TST

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

IGRA

Name of IGRA Test _____ Date Drawn (mm-dd-yyyy) _____

NI Value (3/ind or number of cells) _____ TB Response (TB-nt 3/ind 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

Incomplete vaccine history, no waiver requested

Vaccine history incomplete, requesting waiver (indicate type below)

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) _____

Complete this section for any known syphilis treatment

This section is required for all applicants 2-14 years old (TST or IGRA, not both)

Information in this section should match information on DS-3025 form

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

Vaccine history complete

Incomplete vaccine history, no waiver requested

Vaccine history incomplete, requesting waiver (indicate type below)

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) _____

Select this option for applicants who object on religious or clinical reasons

Select BLANKET WAIVER for applicants with an incomplete vaccination history

This section is REQUIRED if treatment details are known

(4) Tuberculosis Treatment Regimen

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

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

Medication	Dose/Interval (e.g., mg/day)	Start Date (mm-dd-yyyy)	End Date (mm-dd-yyyy)
<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 _____	_____	_____	_____

Pre-treatment weight is ESPECIALLY important for child applicants

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

Remarks _____

(4) Tuberculosis Treatment Regimen

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

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

Medication	Dose/Interval (e.g., mg/day)	Start Date (mm-dd-yyyy)	End Date (mm-dd-yyyy)
<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 STATEMENT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time required for reviewing the final collection. Send comments regarding this burden estimate or any aspect of this collection of information, including suggestions for reducing the burden, to Washington, DC 20522-2022.

CONFIDENTIALITY STATEMENT

CONFIDENTIALITY: The information asked for on this form is requested pursuant to Section 212(a) and 212(b) and as required by Section 222 of the Immigration and Nationality Act. Section 222(i) 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 formation, administration, enforcement 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 tools 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 the 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. law.

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