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| U.S. Department of State  **MEDICAL EXAMINATION FOR IMMIGRANT OR REFUGEE APPLICANT**  **For use with DS-3030**    Photo  OMB No. 1405-0113  EXPIRATION DATE: xx/xx/xxxx  ESTIMATED BURDEN: 10 MINUTES  (See Page 2 – Back of Form) | | | | | | | | | | | | | |  | | | |
| Name *(Last, First, MI)* | | | | | | | | | | Birth Date *(mm-dd-yyyy)* | | | | | | | Sex  M F |
| U.S. Consul *(City, Country)* | | | | | | | | Passport Number | | | | | Alien *(Case)* Number | | | | |
| Birthplace *(City, Country)* | | | | | Present Country of Residence | | | | | | | Prior Country | | | | | |
| Present Address of Residence | | | | | Present City of Residence | | | | | | | Present Postal Code of Residence | | | | | |
| Intended US Address | | | | | Intended US City | | | | | | | Intended US State | | | | | |
| Intended US Postal Code | | E-mail Address | | | | | | | | | | | | | | | |
| Date of Medical Exam *(Date of physical exam or date 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)* | | | | | | | | | | | | | | | | | |
| Exam Place of Current Exam *(City, Country)* | | | | | | | | Date of Prior Exam, if any *(mm-dd-yyyy)* | | | | | | | | | |
| Panel Physician Performing Exam | | | Panel Site | | | | | | | | Radiology Facility | | | | | | |
| Sputum Smear Laboratory | | | Sputum Culture Laboratory | | | | | | | | Syphilis Laboratory | | | | | | |
| Drug Susceptibility Test Laboratory | | | | | | | | DOT Facility | | | | | | | | | |
| Applicant Category  *(Mark One)* | Immigrant Visa  Immigrant  Special Immigrant (SIV)  Diversity  Adoptee | | | Refugee  Refugee  Visa 92 | | | | Asylee  Asylee  Visa 93 | Non-Immigrant Visa (NIV)  K-Visa  Other NIV | | | | | | | Parolee  Parolee | |
| 1. **Classification** *(Check all boxes that apply)*   **No apparent defect, disease, or disability** *(See Worksheets DS-3025, DS-3026, DS-3030)* | | | | | | | | | | | | | | | | | |
| **Class A Conditions** *(See Worksheets DS-3025, DS-3026, DS-3030)* | | | | | | | | | | | | | | | | | |
| Tuberculosis disease  Syphilis, untreated  Chancroid, untreated  Gonorrhea, untreated  Granuloma inguinale, untreated  Lymphogranumoma venerum, untreated | | | | | | | Hansen’s Disease, untreated multibacillary or paucibacillary  Addiction or abuse of specific substance on the CSA  Any physical or mental disorder (including other substance-related disorder) with harmful behavior or history of such behavior likely to recur  Immigrant visa applicant refuses vaccinations | | | | | | | | | | |
| **Class B Conditions** *(See Worksheets DS-3025, DS-3026, DS-3030)* | | | | | | | | | | | | | | | | | |
| Tuberculosis  B1 TB, Pulmonary  B1 TB, Extrapulmonary  B2 TB, LTBI Evaluation  B3 TB, Contact Evaluation  Hansen’s Disease  Multibacillary, treated  Paucibacillary, treated | | | | | | | Syphilis, treated within last year  Any physical or mental disorder (excluding addiction or abuse of specific substance on the CSA but including other substance-related disorder) without harmful behavior or history of such behavior unlikely to recur  Sustained, full remission of addiction or abuse of specific substance on the CSA | | | | | | | | | | |
| **Class B Other** *(Specify or give details from worksheets)* | | | | | | | | | | | | | | | | | |
| 1. **Immunization Documentation for Immigrant Visa Applicants** *(See DS-3025, mark one)*   US vaccination requirements Complete:  Requesting Blanket Waiver  US vaccination requirements NOT Complete:  Requesting Individual Waiver based on religious or moral convictions  Requesting Adoptee Exemption  Applicant refuses vaccinations | | | | | | | | | | | | | | | | | |
| **3. Applicant**  I certify that I understand the purpose of the medical examination and I authorize the required tests to be completed. | | | | | | Applicant signature | | | | | | | | | Date *(mm/dd/yyyy)* | | |
| **4. Panel Physician**  I attest that I performed this examination and that I have an agreement with the Department of State | | | | | | Panel Physician signature | | | | | | | | | Date *(mm/dd/yyyy)* | | |
| **PAPERWORK REDUCTION ACT AND CONFIDENTIALITY STATEMENTS**  **PAPERWORK REDUCTION ACT STATEMENT**  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 PRA\_BurdenComments@state.gov.  **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, in the discretion of the Secretary of State, 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. More information on the Routine Uses for this collection can be found in the System of Records Notice State-24, Medical Records. | | | | | | | | | | | | | | | | | |