

U.S. Department of State
**MEDICAL EXAMINATION FOR
 IMMIGRANT OR REFUGEE APPLICANT**

OMB No. 1405-0113
 EXPIRATION DATE: xx/xx/xxxx
 ESTIMATED BURDEN: 10 MINUTES
 (See Page 2 – Back of Form)

Photo



Name (Last, First, MI)		Birth Date (mm-dd-yyyy)		Sex <input type="checkbox"/> M <input type="checkbox"/> 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 <input type="checkbox"/> Immigrant <input type="checkbox"/> Special Immigrant (SIV) <input type="checkbox"/> Diversity <input type="checkbox"/> Adoptee	Refugee <input type="checkbox"/> Refugee <input type="checkbox"/> Visa 92	Asylee <input type="checkbox"/> Asylee <input type="checkbox"/> Visa 93	Non-Immigrant Visa (NIV) <input type="checkbox"/> K-Visa <input type="checkbox"/> Other NIV	Parolee <input type="checkbox"/> Parolee
1. Classification (Check all boxes that apply)					
<input type="checkbox"/> No apparent defect, disease, or disability (See Worksheets DS-3025, DS-3026, DS-3030)					
<input type="checkbox"/> Class A Conditions (See Worksheets DS-3025, DS-3026, DS-3030)					
<input type="checkbox"/> Tuberculosis disease		<input type="checkbox"/> Hansen's Disease, untreated multibacillary or paucibacillary			
<input type="checkbox"/> Syphilis, untreated		<input type="checkbox"/> Addiction or abuse of specific substance on the CSA			
<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"/> Immigrant visa applicant refuses vaccinations			
<input type="checkbox"/> Granuloma inguinale, untreated					
<input type="checkbox"/> Lymphogranuloma venerum, untreated					
<input type="checkbox"/> Class B Conditions (See Worksheets DS-3025, DS-3026, DS-3030)					
Tuberculosis		<input type="checkbox"/> Syphilis, treated within last year			
<input type="checkbox"/> B1 TB, Pulmonary		<input type="checkbox"/> 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			
<input type="checkbox"/> B1 TB, Extrapulmonary		<input type="checkbox"/> Sustained, full remission of addiction or abuse of specific substance on the CSA			
<input type="checkbox"/> B2 TB, LTBI Evaluation					
<input type="checkbox"/> B3 TB, Contact Evaluation					
Hansen's Disease					
<input type="checkbox"/> Multibacillary, treated					
<input type="checkbox"/> Paucibacillary, treated					

Class B Other (Specify or give details from worksheets)

2. 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.