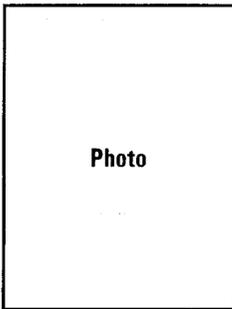




U. S. Department of State
**MEDICAL EXAMINATION FOR
 IMMIGRANT OR REFUGEE APPLICANT**

OMB No. 1405-0113
 EXPIRATION DATE: 1/31/2004
 ESTIMATED BURDEN: 40 minutes (See Page 2 -
 Back of Form)



Photo

Name (Last, First, MI) _____

Birth Date (mm-dd-yyyy) _____

Birthplace (City/Country) _____

Present Country of Residence _____

U. S. Consul (City/Country) _____

Passport Number _____

SEX: M F

Prior Country _____

Alien (Case) Number _____

Date Exam Expires (6 months from examination date, if Class A or TB condition exists, otherwise 12 months) (mm-dd-yyyy) _____

Exam Place (City/Country) _____

Panel Physician (name) _____

Radiology Services (name) _____

Screening Site (name) _____

Lab (name for HIV/syphilis/TB) _____

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

No apparent defect, disease, or disability (see Worksheets DS-3024, DS-3025 and DS-3026)

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

- TB, active, infectious (Class A, from Chest X-Ray Worksheet)
- Syphilis, untreated
- Chancroid, untreated
- Gonorrhea, untreated
- Granuloma inguinale, untreated
- Lymphogranuloma venereum, untreated

- Human immunodeficiency virus (HIV)
- Hansen's disease, lepromatous or multibacillary
- Addiction or abuse of specific* substance without harmful behavior
- Any physical or mental disorder (including other substance-related disorder) with harmful behavior or history of such behavior likely to recur

*amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics

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

- TB, active, noninfectious (Class B1, from Chest X-Ray Worksheet)
 Treatment: None Partial Completed
- TB, inactive (Class B2, from Chest X-Ray Worksheet)
 Treatment: None Partial Completed
- Syphilis, treated within last year
- Other sexually transmitted infections, treated within last year
- Current pregnancy, number of weeks pregnant _____
- Other (specify or give details on checked conditions from worksheets) _____

- Hansen's disease, prior treatment
- Hansen's disease, tuberculoid, borderline, or paucibacillary
- Sustained, full remission of addiction or abuse of specific* substances
- 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

*amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics

(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			<input type="checkbox"/>	<input type="checkbox"/>		
Confirmatory			<input type="checkbox"/>	<input type="checkbox"/>		
Treated	If treated, therapy:				Dates(s) treatment given (3 doses for penicillin)	
<input type="checkbox"/> Yes	<input type="checkbox"/> Benzathine penicillin, 2.4 MU IM					
<input type="checkbox"/> No	<input type="checkbox"/> Other (therapy, dose):					

HIV: Not done

	Test name	Date(s) run (mm-dd-yyyy)	Negative	Positive	Indeterminate	Notes
Screening			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Secondary			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Confirmatory			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

(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)

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

Public reporting burden for this collection of information is estimated to average 40 minutes per response, including time required for searching existing data sources, gathering the necessary data, providing the information required, and reviewing the final collection. Persons are not required to provide this information in the absence of a valid OMB approval number. Send comments on the accuracy of this estimate of the burden and recommendations for reducing it to: Department of State (A/RPS/DIR) Washington, DC 20520-1849.

We ask for information on this form, in the case of applicants for immigrant visas, to determine medical eligibility under INA Sections 212(a) and 221(d), and, in the case of refugees, as required under INA Section 412(b)(4) and (5). If an immigrant visa is issued or refugee status granted, you will convey this form to the INS for disclosure to the Center for Disease Control and the US Public Health Service. Failure to provide this information may delay or prevent the processing of your case. If an immigrant visa is not issued or refugee status is not granted, this form will be treated as confidential under INA Section 222(f).