U. S. Department of State

MEDICAL EXAMINATION FOR IMMIGRANT OR REFUGEE APPLICANT

OMB No. 1405-0113
EXPIRATION DATE: 09/30/2010
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 *(mm-dd-yyyy)* **of Medical Exam** _____ **Date** *(mm-dd-yyyy)* **of Prior Exam, if any** _____

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** _____

Radiology Services _____ **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
  See Section 4 on page 2 for TB treatment details
- ☐ Syphilis *(with residual deficit)*, treated within the 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			☐	☐		
Confirmatory			☐	☐		

Treated	If treated, therapy:	Date(s) treatment given *(3 doses for penicillin)*
☐ Yes	☐ Benzathine penicillin, 2.4 MU IM	
☐ No	☐ Other *(therapy, dose)*:E	

HIV: ☐ **Not done**

	Test name	Date(s) run *(mm-dd-yyyy)*	Negative	Positive	Indeterminate	Notes
Screening			☐	☐	☐	
Secondary			☐	☐	☐	
Confirmatory			☐	☐	☐	

(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")*

Medication	Dose/Interval *(i.e., mg/day)*	Start Date *(mm-dd-yyyy)*	End Date *(mm-dd-yyyy)*
☐ Isonaizid (INH)			
☐ Rifampin			
☐ Pyrazinamide			
☐ Ethambutol			
☐ Streptomycin			
☐ Other, specify			

Applicant's weight (kg) _____

Remarks _____

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

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 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: U.S. Department of State (A/RPS/DIR) Washington, DC 20520.

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 U.S. Department of Homeland Security (DHS) for disclosure to the Centers for Disease Control and Prevention and to the U.S. 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).

U.S. Department of State

CHEST X-RAY AND CLASSIFICATION WORKSHEET

For Use with DS-2053 Complete Sections 1 through 5, As Applicable

OMB APPROVEDS No. 1405-0113
EXPIRATION DATE: 09-30-2010
ESTIMATED BURDEN: 10 MINUTES
(See Page 2 - Back of Form)

Name *(Last, First, MI.)* | Age

Birth Date *(mm-dd-yyyy)* | Passport Number | Alien (Case) Number

1. Chest X-Ray *(Mark All that Apply)*

- ☐ History of Tuberculosis *(TB)* Disease
- ☐ Contact with Person with TB
- ☐ TB Signs or Symptoms
- ☐ Adult *(With or Without Any of the Other)*

(If child does not have any of the above, stop here.)

2. Chest X-Ray Findings

Date Chest X-Ray Taken *(mm-dd-yyyy)* _____

- ☐ Normal Findings
- ☐ Abnormal Findings *(Indicate findings and interpretation, by checking all that apply, and any other in the table below.)*

☐ **Can Suggest ACTIVE TB** *(Need Smears)*	☐ **Can Suggest INACTIVE TB** *(Need Smears if Symptomatic)*	☐ **OTHER X-Ray Findings**
☐ Infiltrate or Consolidation	☐ Discrete Fibrotic Scar or Linear Opacity	☐ **Follow-Up Needed**
☐ Any Cavitary Lesion	☐ Discrete Nodule*(s)* without Calcification	☐ Musculoskeletal
☐ Nodule with Poorly Defined Margins *(Such as Tuberculoma)*	☐ Discrete Fibrotic Scar with Volume Loss or Retraction	☐ Cardiac
☐ Pleural Effusion	☐ Discrete Nodule*(s)* with Volume Loss or Retraction	☐ Pulmonary
☐ Hilar/Mediastinal Adenopathy	☐ Other *(Such as Bronchiectasis)*	☐ Other
☐ Linear, Interstitial Markings		☐ **No Follow-Up Needed for** Pleural thickening, diaphragmatic tenting, blunting costophrenic angle, solitary calcified nodule or granuloma or minor musculoskeletal or cardiac finding
☐ Other *(Such as Miliary Findings)*		

Remarks

3. Sputum Smears

☐ **No, Applicant has No Signs or Symptoms of TB and :**

- ☐ X-Ray Suggests INACTIVE TB, this is a **Class B2/TB**
- ☐ OTHER X-Ray Findings Suggest Follow-Up Needed after Arrival, this is **B Other**
- ☐ OTHER X-Ray Findings Suggest N**o Follow-Up Needed,** this is **No Class**
- ☐ X-Ray Normal, this is **No Class**

☐ **Yes, Applicant has** *(Mark All that Apply)* :

- ☐ Signs or Symptoms of TB Present, See Section 1
- ☐ X-Ray Suggests ACTIVE TB, See Section 2

and Smear Results are:

Positive	Negative	Dates Obtained *(mm-dd-yyyy)*
☐	☐	_____
☐	☐	_____
☐	☐	_____

Sputum Smear Results and X-Ray

At least One Smear Result POSITIVE and

☐ Any Chest X-Ray Finding, this is **Class** *(Normal or Abnormal findings)*

Three Smear Results NEGATIVE and

☐ X-Ray Normal with

- ☐ Signs of Symptoms Resolved, this is **No Class**
- ☐ Signs or Symptoms Suggest Follow-Up Needed after Arrival, this is **B Other**

☐ X-Ray Suggests ACTIVE or INACTIVE TB, this is **Class B1/TB**

☐ OTHER X-Ray Findings Suggest Follow-Up Needed After Arrival, this is **Class B**

4. ☐ **No Class** ☐ **Class A/TB** ☐ **Class B1/TB** ☐ **Class B2/TB** ☐ **Class B Other, Follow-Up**

5. Follow-Up Needed After ☐ No ☐ Yes If Yes, for ☐ Not TB Condition ☐ TB Condition

*(If yes, specify condition below **and** on DS-2053; include additional tests, and therapy used with start and stop dates and any changes.)*

Remarks

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

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AUTHORITIES The information is sought pursuant to Sections 212(a), 221(d), 101, and 412(b)(4) and (5) of the Immigration and Nationality Act.

PURPOSE The primary purpose for soliciting medical information is to determine whether an applicant is eligible to obtain a visa and alien registration. This form is designed to record the result of the medical examination required by INA 221(d), which determines whether an applicant has a medical condition that renders the applicant ineligible under INA Section 212(a).

ROUTINE USES The information solicited on this form may be made available to the U.S. Department of Homeland Security for disclosure to the Centers for Disease Control and Prevention and to the U.S. Public Health Service. The information provided also may be released to federal agencies for law enforcement, counter-terrorism and homeland security purposes; to Congress and courts within their sphere of jurisdiction; and to other federal agencies for certain personnel and records management matters.

Although furnishing this information is voluntary, failure to provide this information may delay or prevent the processing of your case.

U.S. Department of State

VACCINATION DOCUMENTATION WORKSHEET

For Use with DS-2053 To Be Completed by Panel Physician Only

OMB No. 1405-0113
EXPIRATION DATE: 09/30/2010
ESTIMATED BURDEN: 20 minutes
(See Page 2 - Back of Form)

Name *(Last, First, MI.)*		Exam Date *(mm-dd-yyyy)*
Birth Date *(mm-dd-yyyy)*	Passport Number	Alien *(Case)* Number

REQUIRED FOR U.S. IMMIGRANT VISA APPLICANTS

NOT REQUIRED FOR REFUGEE APPLICANTS

NOTE FOR PANEL PHYSICIANS:
For refugee applicants, please complete only if reliable vaccination documents are available.

1. Immunization Record

Vaccine	Vaccine History Transferred From a Written Record *(List Chronologically from Left to Right)* Date Received *(mm-dd-yyyy)*	Date Received *(mm-dd-yyyy)*	Date Received *(mm-dd-yyyy)*	Date Received *(mm-dd-yyyy)*	Vaccine Given by Panel Physician *(mm-dd-yyyy)*	Completed Series *(✓ if Completed, Write "VH" if Varicella History, or write Date of Lab Test if Immune)*	Blanket Waiver(s) To Be Requested If Vaccination Not Medically Appropriate, Check Suitable Box(es) Below: Not Age Appropriate	Insufficient Time Interval	Contra-indicated	Not Routinely Available	Not Fall *(Flu)* Season
DT/DTP/DTaP							☐	☐	☐	☐	☐
Td							☐	☐	☐	☐	☐
Polio *(OPV/IPV)*							☐	☐	☐	☐	☐
Measles *(or MR or MMR)*							☐	☐	☐	☐	☐
Mumps *(or MMR)*							☐	☐	☐	☐	☐
Rubella *(or MR or MMR)*							☐	☐	☐	☐	☐
Rotavirus							☐	☐	☐	☐	
Hib *(Haemophilus Influenzae Type B)*							☐	☐	☐	☐	☐
Hepatitis A							☐	☐	☐	☐	☐
Hepatitis B							☐	☐	☐	☐	☐
Meningococcal							☐	☐	☐	☐	☐
Human papillomavirus							☐	☐	☐	☐	☐
Varicella							☐	☐	☐	☐	
Pneumococcal							☐	☐	☐	☐	☐
Influenza							☐	☐	☐	☐	☐

2. Results

- ☐ Vaccine History Incomplete
  - ☐ Applicant may be eligible for blanket waiver(s) because vaccination(s) not medically appropriate *(as Indicated Above)*.
  - ☐ Applicant will request an individual waiver based on religious or moral convictions.
- ☐ Vaccine history complete for each vaccine, all requirements met *(Documented Above)*.
- ☐ Applicant does not meet vaccination requirements for one or more vaccines and no waiver is requested.

3. Panel Physician *(Name)* _____

Panel Physician *(Signature)* _____

Date *(mm-dd-yyyy)* _____

PRIVACY ACT NOTICE

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PAPERWORK REDUCTION ACT NOTICE

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the U.S. Department of State (A/ISS/DIR) Washington, DC 20520-1849.

U.S. Department of State

MEDICAL HISTORY AND PHYSICAL EXAMINATION WORKSHEET

For use with DS-2053

OMB No. 1405-0113
EXPIRATION DATE: 09/30/2010
ESTIMATED BURDEN: 35 minutes
(See Page 2 - Back of Form)

Name *(Last, First, MI)*		Exam Date *(mm-dd-yyyy)*
Birth Date *(mm-dd-yyyy)*	Passport Number	Alien *(Case)* Number

1. Past Medical History *(indicate conditions requiring medication or other treatment after resettlement and give details in Remarks)*

NOTE: The following history has been reported, has not been verified by a physician, and should not be deemed medically definitive.

No	Yes	
		General
☐	☐	Illness or injury requiring hospitalization *(including psychiatric)*
		Cardiology
☐	☐	Angina pectoris
☐	☐	Hypertension *(high blood pressure)*
☐	☐	Cardiac arrhythmia
☐	☐	Congenital heart disease
		Pulmonology
☐	☐	History of tobacco use Current use ☐ Yes ☐ No
☐	☐	Asthma
☐	☐	Chronic obstructive pulmonary disease *(emphysema)*
☐	☐	History of tuberculosis *(TB)* disease Treated ☐ Yes ☐ No Current TB symptoms ☐ Yes ☐ No
		Neurology and Psychiatry
☐	☐	History of stroke, with current impairment
☐	☐	Seizure disorder
☐	☐	Major impairement in learning, intelligence, self care, memory, or communication
☐	☐	Major mental disorder *(including major depression, bipolar disorder, schizophrenia, mental retardation)*
☐	☐	Use of drugs other than those required for medical reasons
☐	☐	Addiction or abuse of specific* substance *(drug)* *amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics
☐	☐	Other substance-related disorders *(including alcohol addiciton or abuse)*
☐	☐	Ever taken action to end your life

No	Yes	
☐	☐	Ever caused SERIOUS injury to others, caused MAJOR property damage or had trouble with the law because of medical condition, mental disorder, or influence of alcohol or drugs
		Obstetrics and Sexually Transmitted Diseases
☐	☐	Pregnancy Fundal height _____ cm Last menstrual period Date *(mm-dd-yyyy)* _____
☐	☐	Sexually transmitted diseases, specify _____
		Endocrinology and Hematology
☐	☐	Diabetes mellitus
☐	☐	Thyroid disease
☐	☐	History of malaria
		Other
☐	☐	Malignancy, specify _____
☐	☐	Chronic renal disease
☐	☐	Chronic hepatitis or other chronic liver disease
☐	☐	Hansen's Disease ☐ Tuberculoid ☐ Borderline ☐ Lepromatous *OR* ☐ Paucibacillary ☐ Multibacillary Treated ☐ Yes ☐ No
☐	☐	Visible disabilities *(including loss of arms or legs)*, specify
☐	☐	Other requiring treatment, specify

2. Physical Examination *(indicate findings and give details in Remarks)*

☐ No ☐ Yes Applicant appears to be providing unreliable or false information, specify

Height _____ cm Weight _____ kg Visual Acuity at 20 feet: Uncorrected L 20/ _____ R 20/ _____

BP ____ /____ *(mmHg)* Heart rate _____ /min Respiratory rate ____ /min Corrected L 20/ _____ R 20/ _____

***N, normal; A, abnormal; ND, not done**

N*	A*	ND*		N*	A*	ND*	
☐	☐	☐	General appearance and nutritional status	☐	☐	☐	Inguinal region *(including adenopathy)*
☐	☐	☐	Hearing and ears	☐	☐	☐	Extremities *(including pulses, edema)*
☐	☐	☐	Eyes	☐	☐	☐	Musculoskeletal system *(including gait)*
☐	☐	☐	Nose, mouth, and throat *(include dental)*	☐	☐	☐	Skin *(including hypopigmentation, anesthesia, findings consistent with self-inflicted injury or injections)*
☐	☐	☐	Heart *(S1, S2, murmur, rub)*	☐	☐	☐	Lymph nodes
☐	☐	☐	Breast	☐	☐	☐	Nervous system *(including nerve enlargement)*
☐	☐	☐	Lungs	☐	☐	☐	Mental status *(including mood, intelligence, perception, thought processes, and behavior during examination)*
☐	☐	☐	Abdomen *(including liver, spleen)*				
☐	☐	☐	Genitalia *(including circumcision, infection(s))*				

3. Additional Testing Needed Prior to Approving Medical Clearance

No Yes

☐ ☐ Physical examination or laboratory results contradict medical history

☐ ☐ Referral prior to departure If yes, provide results _____

☐ ☐ Referral prior to departure If yes, provide results _____

4. Follow-up Needed After Arrival

☐ No ☐ Yes, within 1 week ☐ Yes, within 1 month ☐ Yes, within 6 months

☐ For continuing medication, list type, dose, and frequency _____

☐ For continuing other treatment, specify _____

5. Remarks *(describe any abnormal history, abnormal findings, and resulting interventions)*

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