



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		<input type="checkbox"/>	<input type="checkbox"/>		
Confirmatory		<input type="checkbox"/>	<input type="checkbox"/>		

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

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)

(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")

<u>Medication</u>	<u>Dose/Interval</u> <i>(i.e., mg/day)</i>	<u>Start Date</u> <i>(mm-dd-yyyy)</i>	<u>End Date</u> <i>(mm-dd-yyyy)</i>
<input type="checkbox"/> Isonaizid (INH)	_____	_____	_____
<input type="checkbox"/> Rifampin	_____	_____	_____
<input type="checkbox"/> Pyrazinamide	_____	_____	_____
<input type="checkbox"/> Ethambutol	_____	_____	_____
<input type="checkbox"/> Streptomycin	_____	_____	_____
<input type="checkbox"/> 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).



CHEST X-RAY AND CLASSIFICATION WORKSHEET

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

For Use with DS-2053

Complete Sections 1 through 5, As Applicable

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

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

<input type="checkbox"/> History of Tuberculosis (TB) Disease	<input type="checkbox"/> TB Signs or Symptoms
<input type="checkbox"/> Contact with Person with TB	<input type="checkbox"/> 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.)

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

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 **No Follow-Up Needed**, this is **No Class**
- X-Ray Normal, this is **No Class**

Yes, Applicant has (Mark All that Apply) :

<input type="checkbox"/> Signs or Symptoms of TB Present, See Section 1 <input type="checkbox"/> X-Ray Suggests ACTIVE TB, See Section 2	and Smear Results are: <table style="width:100%;"> <tr> <th style="width:50%;">Positive</th> <th style="width:50%;">Negative</th> <th style="width:50%;">Dates Obtained (mm-dd-yyyy)</th> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>_____</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>_____</td> </tr> </table>	Positive	Negative	Dates Obtained (mm-dd-yyyy)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Positive	Negative	Dates Obtained (mm-dd-yyyy)											
<input type="checkbox"/>	<input type="checkbox"/>	_____											
<input type="checkbox"/>	<input type="checkbox"/>	_____											
<input type="checkbox"/>	<input type="checkbox"/>	_____											

Sputum Smear Results and X-Ray At least One Smear Result POSITIVE and <input type="checkbox"/> Any Chest X-Ray Finding, this is Class (Normal or Abnormal findings)	Three Smear Results NEGATIVE and <input type="checkbox"/> X-Ray Normal with <input type="checkbox"/> Signs of Symptoms Resolved, this is No Class <input type="checkbox"/> Signs or Symptoms Suggest Follow-Up Needed after Arrival, this is B Other <input type="checkbox"/> X-Ray Suggests ACTIVE or INACTIVE TB, this is Class B1/TB <input type="checkbox"/> OTHER X-Ray Findings Suggest Follow-Up Needed After Arrival, this is Class B
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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

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

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.



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

1. Immunization Record

Vaccine	Vaccine History Transferred From a Written Record (List Chronologically from Left to Right)				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				
	Date Received (mm-dd-yyyy)	Date Received (mm-dd-yyyy)	Date Received (mm-dd-yyyy)	Date Received (mm-dd-yyyy)			Not Age Appropriate	Insufficient Time Interval	Contra- indicated	Not Routinely Available	Not Fall (Flu) Season
DT/DTP/DTaP							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Td							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Polio (OPV/IPV)							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Measles (or MR or MMR)							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mumps (or MMR)							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rubella (or MR or MMR)							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rotavirus							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hib (Haemophilus Influenzae Type B)							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis A							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meningococcal							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Human papillomavirus							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Varicella							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pneumococcal							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Influenza							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

AUTHORITIES: This information is sought pursuant to Section 212(a), 212(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 of 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.

PAPERWORK REDUCTION ACT NOTICE

Public reporting burden for this collection of information is estimated to average 30 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 burden and recommendations for reducing it to : the U.S. Department of State (A/ISS/DIR) Washington, DC 20520-1849.

U.S. Department of State
MEDICAL HISTORY AND PHYSICAL EXAMINATION WORKSHEET

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

For use with DS-2053

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

<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;">No</td> <td style="width:10%;">Yes</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>General</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Illness or injury requiring hospitalization (including psychiatric)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Cardiology</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Angina pectoris</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hypertension (high blood pressure)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Cardiac arrhythmia</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Congenital heart disease</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Pulmonology</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>History of tobacco use</td> </tr> <tr> <td></td> <td></td> <td> Current use <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Asthma</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Chronic obstructive pulmonary disease (emphysema)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>History of tuberculosis (TB) disease</td> </tr> <tr> <td></td> <td></td> <td> Treated <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td></td> <td></td> <td> Current TB symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Neurology and Psychiatry</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>History of stroke, with current impairment</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Seizure disorder</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Major impairment in learning, intelligence, self care, memory, or communication</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Major mental disorder (including major depression, bipolar disorder, schizophrenia, mental retardation)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Use of drugs other than those required for medical reasons</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Addiction or abuse of specific* substance (drug)</td> </tr> <tr> <td></td> <td></td> <td> *amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Other substance-related disorders (including alcohol addiction or abuse)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Ever taken action to end your life</td> </tr> </table>	No	Yes		<input type="checkbox"/>	<input type="checkbox"/>	General	<input type="checkbox"/>	<input type="checkbox"/>	Illness or injury requiring hospitalization (including psychiatric)	<input type="checkbox"/>	<input type="checkbox"/>	Cardiology	<input type="checkbox"/>	<input type="checkbox"/>	Angina pectoris	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension (high blood pressure)	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>	Congenital heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonology	<input type="checkbox"/>	<input type="checkbox"/>	History of tobacco use			Current use <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Chronic obstructive pulmonary disease (emphysema)	<input type="checkbox"/>	<input type="checkbox"/>	History of tuberculosis (TB) disease			Treated <input type="checkbox"/> Yes <input type="checkbox"/> No			Current TB symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	Neurology and Psychiatry	<input type="checkbox"/>	<input type="checkbox"/>	History of stroke, with current impairment	<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>	Major impairment in learning, intelligence, self care, memory, or communication	<input type="checkbox"/>	<input type="checkbox"/>	Major mental disorder (including major depression, bipolar disorder, schizophrenia, mental retardation)	<input type="checkbox"/>	<input type="checkbox"/>	Use of drugs other than those required for medical reasons	<input type="checkbox"/>	<input type="checkbox"/>	Addiction or abuse of specific* substance (drug)			*amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics	<input type="checkbox"/>	<input type="checkbox"/>	Other substance-related disorders (including alcohol addiction or abuse)	<input type="checkbox"/>	<input type="checkbox"/>	Ever taken action to end your life	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;">No</td> <td style="width:10%;">Yes</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>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</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Obstetrics and Sexually Transmitted Diseases</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Pregnancy Fundal height _____ cm</td> </tr> <tr> <td></td> <td></td> <td> Last menstrual period Date (mm-dd-yyyy) _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Sexually transmitted diseases, specify _____</td> </tr> <tr> <td></td> <td></td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Endocrinology and Hematology</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Diabetes mellitus</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Thyroid disease</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>History of malaria</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Other</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Malignancy, specify _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Chronic renal disease</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Chronic hepatitis or other chronic liver disease</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hansen's Disease</td> </tr> <tr> <td></td> <td></td> <td> <input type="checkbox"/> Tuberculoid <input type="checkbox"/> Borderline <input type="checkbox"/> Lepromatous</td> </tr> <tr> <td></td> <td></td> <td> OR <input type="checkbox"/> Paucibacillary <input type="checkbox"/> Multibacillary</td> </tr> <tr> <td></td> <td></td> <td> Treated <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Visible disabilities (including loss of arms or legs), specify _____</td> </tr> <tr> <td></td> <td></td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Other requiring treatment, specify _____</td> </tr> <tr> <td></td> <td></td> <td>_____</td> </tr> <tr> <td></td> <td></td> <td>_____</td> </tr> </table>	No	Yes		<input type="checkbox"/>	<input type="checkbox"/>	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	<input type="checkbox"/>	<input type="checkbox"/>	Obstetrics and Sexually Transmitted Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy Fundal height _____ cm			Last menstrual period Date (mm-dd-yyyy) _____	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted diseases, specify _____			_____	<input type="checkbox"/>	<input type="checkbox"/>	Endocrinology and Hematology	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes mellitus	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	History of malaria	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	Malignancy, specify _____	<input type="checkbox"/>	<input type="checkbox"/>	Chronic renal disease	<input type="checkbox"/>	<input type="checkbox"/>	Chronic hepatitis or other chronic liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Hansen's Disease			<input type="checkbox"/> Tuberculoid <input type="checkbox"/> Borderline <input type="checkbox"/> Lepromatous			OR <input type="checkbox"/> Paucibacillary <input type="checkbox"/> Multibacillary			Treated <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	Visible disabilities (including loss of arms or legs), specify _____			_____	<input type="checkbox"/>	<input type="checkbox"/>	Other requiring treatment, specify _____			_____			_____
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		Current use <input type="checkbox"/> Yes <input type="checkbox"/> No																																																																																																																																																					
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		Current TB symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No																																																																																																																																																					
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<input type="checkbox"/>	<input type="checkbox"/>	History of stroke, with current impairment																																																																																																																																																					
<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorder																																																																																																																																																					
<input type="checkbox"/>	<input type="checkbox"/>	Major impairment in learning, intelligence, self care, memory, or communication																																																																																																																																																					
<input type="checkbox"/>	<input type="checkbox"/>	Major mental disorder (including major depression, bipolar disorder, schizophrenia, mental retardation)																																																																																																																																																					
<input type="checkbox"/>	<input type="checkbox"/>	Use of drugs other than those required for medical reasons																																																																																																																																																					
<input type="checkbox"/>	<input type="checkbox"/>	Addiction or abuse of specific* substance (drug)																																																																																																																																																					
		*amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics																																																																																																																																																					
<input type="checkbox"/>	<input type="checkbox"/>	Other substance-related disorders (including alcohol addiction or abuse)																																																																																																																																																					
<input type="checkbox"/>	<input type="checkbox"/>	Ever taken action to end your life																																																																																																																																																					
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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**

<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;">N*</td> <td style="width:10%;">A*</td> <td style="width:10%;">ND*</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>General appearance and nutritional status</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hearing and ears</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Eyes</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Nose, mouth, and throat (include dental)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Heart (S1, S2, murmur, rub)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Breast</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Lungs</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Abdomen (including liver, spleen)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Genitalia (including circumcision, infection(s))</td> </tr> </table>	N*	A*	ND*		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	General appearance and nutritional status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing and ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose, mouth, and throat (include dental)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart (S1, S2, murmur, rub)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen (including liver, spleen)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia (including circumcision, infection(s))	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;">N*</td> <td style="width:10%;">A*</td> <td style="width:10%;">ND*</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Inguinal region (including adenopathy)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Extremities (including pulses, edema)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Musculoskeletal system (including gait)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Skin (including hypopigmentation, anesthesia, findings consistent with self-inflicted injury or injections)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Lymph nodes</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Nervous system (including nerve enlargement)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Mental status (including mood, intelligence, perception, thought processes, and behavior during examination)</td> </tr> </table>	N*	A*	ND*		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inguinal region (including adenopathy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities (including pulses, edema)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal system (including gait)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin (including hypopigmentation, anesthesia, findings consistent with self-inflicted injury or injections)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervous system (including nerve enlargement)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental status (including mood, intelligence, perception, thought processes, and behavior during examination)
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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)*

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

Public reporting burden for this collection of information is estimated to average 35 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: the U.S. Department of State (A/ISS/DIR) Washington, DC 20520.

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.