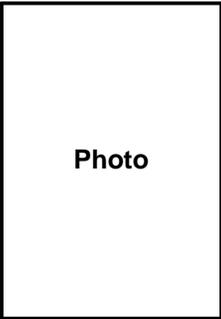




U.S. Department of State
**MEDICAL EXAMINATION FOR
 IMMIGRANT OR REFUGEE APPLICANT**

OMB No. 1405-0113
 EXPIRATION DATE: 08/31/2014
 ESTIMATED BURDEN: 10 minutes
 (See Page 2 - Back of Form)

For use with TB Technical Instructions 2007 and the DS-3030



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 of Medical Exam (Date of TB physical exam or date of lab report 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) _____

Date (mm-dd-yyyy) of Prior Exam, if any _____ **Exam Place** (City/Country) _____ / _____

Panel Physician _____ **Radiology Services** _____

Screening Site _____ **Lab** (Name for syphilis/TB) _____ / _____

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

No apparent defect, disease, or disability (See Worksheets DS-3025, DS-3026, and DS-3030)

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

- | | |
|---|---|
| <input type="checkbox"/> TB, active, infectious (Class A, from Chest X-Ray Worksheet) | <input type="checkbox"/> Hansen's disease, untreated multibacillary |
| <input type="checkbox"/> Syphilis, untreated | <input type="checkbox"/> Addiction or abuse of specific* substance |
| <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"/> Granuloma inguinale, untreated | *amphetamines, cannabis, cocaine, hallucinogens, opioids, phencyclidines, sedative-hypnotics, and anxiolytics |
| <input type="checkbox"/> Lymphogranuloma venereum, untreated | |

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

- | | |
|--|---|
| <input type="checkbox"/> Syphilis (with residual defect), treated within the last year | <input type="checkbox"/> Hansen's disease, treated multibacillary
Treatment: <input type="checkbox"/> Partial <input type="checkbox"/> Completed |
| <input type="checkbox"/> Current pregnancy, number of weeks pregnant _____ | <input type="checkbox"/> Hansen's disease, paucibacillary
Treatment: <input type="checkbox"/> None <input type="checkbox"/> Partial <input type="checkbox"/> Completed |
| <input type="checkbox"/> 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 | <input type="checkbox"/> Sustained, full remission of addiction or abuse of specific* substances |
- *amphetamines, cannabis, cocaine, hallucinogens, opioids, phencyclidines, sedative-hypnotics, and anxiolytics

Class B1 TB, Pulmonary

- No treatment
- Completed treatment (Check all that apply and attach all laboratory and DOT documents)
- | | |
|--|---|
| <input type="checkbox"/> By panel physician | <input type="checkbox"/> By non-panel physician |
| <input type="checkbox"/> Initial smear positive | <input type="checkbox"/> Initial culture positive |
| <input type="checkbox"/> Pre-treatment culture and DST results performed/available | <input type="checkbox"/> Pre-treatment culture and/or DST results not performed/available |

Class B1 TB, Extrapulmonary

Anatomic Site of Disease _____

- No treatment
- Current treatment
- Completed treatment

Class B2 TB, LTBI Evaluation

- Test for TB infection positive: TST _____ mm; IGRA positive Result _____ TST or IGRA Conversion
- No LTBI treatment
- Current LTBI treatment (Indicate medications in Part 4 of DS-2054 form)
- Completed LTBI treatment (Indicate medications in Part 4 of DS-2054 form)

Class B Tuberculosis - Continued

Class B3 TB, Contact Evaluation

TST _____ mm IGRA negative IGRA positive IGRA Result _____

No preventive treatment

Current preventive treatment (*Indicate medications in Part 4 of DS-2054 form*)

Completed preventive treatment (*Indicate medications in Part 4 of DS-2054 form*)

Source Case: Name _____

Alien Number _____

Relationship to Contact _____

Date Contact Ended (*mm-dd-yyyy*) _____

Type of Source Case TB (*Mark only one and ATTACH DST RESULTS*)

Pansusceptible TB

MDR TB (*resistant to at least INH and rifampin*)

Drug-resistant TB other than MDR TB

Culture negative

Culture results not available

Class B Other (*specify or give details on checked conditions from worksheets*) _____

(2) Laboratory Findings (*check all boxes that apply*):

Syphilis: **Not done**

	Test Name	Date(s) Run (<i>mm-dd-yyyy</i>)	Negative	Positive	Titer 1	Notes
Screening						
Confirmatory						

Treated If treated, therapy: Date(s) treatment given (*mm-dd-yyyy*) (*3 doses for penicillin*)

Yes Benzathine penicillin, 2.4 MU IM _____

No Other (*therapy, dose*): _____

Test for Cell-Mediated Immunity to TB (*Required for all applicants 2 through 14 years of age; perform one type only*)

TST
Date Applied (*mm-dd-yyyy*) _____ Result (*mm*) _____

IGRA
Name of IGRA Test _____ Date Drawn (*mm-dd-yyyy*) _____
Nil Value (IU/ml or number of cells) _____ TB Response (*TB- nil IU/ml or number of cells**) _____

IGRA Interpretation: Positive Negative Indeterminate, Borderline, or Equivocal

* For T-Spot, TB Response number of cells = Higher of Panel A or Panel B minus nil value

(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>(e.g., mg/day)</i>	<u>Start Date</u> <i>(mm-dd-yyyy)</i>	<u>End Date</u> <i>(mm-dd-yyyy)</i>
<input type="checkbox"/> Isoniazid (INH)	_____	_____	_____
<input type="checkbox"/> Rifampin	_____	_____	_____
<input type="checkbox"/> Pyrazinamide	_____	_____	_____
<input type="checkbox"/> Ethambutol	_____	_____	_____
<input type="checkbox"/> Streptomycin	_____	_____	_____
<input type="checkbox"/> Other, specify	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Applicant's pre-treatment weight (kg) _____

Date (mm-dd-yyyy) _____

Remarks _____

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: A/GIS/DIR, Room 2400 SA-22, U.S. Department of State, Washington, DC 20522-2202

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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.



CHEST X-RAY AND CLASSIFICATION WORKSHEET

For use with TB TI 2007 and the DS-2054

Complete Sections 1 through 5, As Applicable

OMB No. 1405-0113
EXPIRATION DATE: 08/31/2014
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 Indication (Mark all that apply)

<input type="checkbox"/> Age ≥ 15 years	<input type="checkbox"/> TST ≥ 10 mm
<input type="checkbox"/> Signs or symptoms of tuberculosis	<input type="checkbox"/> IGRA Positive
<input type="checkbox"/> HIV infection	<input type="checkbox"/> Contact: TST ≥ 5 mm

Test for TB infection:

2. Chest X-Ray Findings

Normal Findings

Abnormal Findings (Indicate category and finding, checking all that apply in the table below.)

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

<input type="checkbox"/> Can Suggest Tuberculosis (Need Smears and Cultures)	<input type="checkbox"/> Other X-Ray Findings
<input type="checkbox"/> Infiltrate or consolidation <input type="checkbox"/> Any cavitary lesion <input type="checkbox"/> Nodule or mass with poorly defined margins (such as tuberculosis) <input type="checkbox"/> Pleural effusion* <input type="checkbox"/> Hilar/mediastinal adenopathy with or without atelectasis <input type="checkbox"/> Other (such as miliary findings) <small>* If unclear whether pleural fluid or thickening, perform lateral or decubitus chest radiograph, or targeted ultrasound.</small>	<input type="checkbox"/> Discrete linear opacity (fibrotic scar) <input type="checkbox"/> Discrete nodule(s) without calcification <input type="checkbox"/> Discrete linear opacity (fibrotic scar) with volume loss or retraction <input type="checkbox"/> Other (such as bronchiectasis)
	<input type="checkbox"/> Follow-up needed (Mark as Class B Other) <ul style="list-style-type: none"> <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Cardiac <input type="checkbox"/> Pulmonary, non-TB (e.g., emphysema) <input type="checkbox"/> Other <input type="checkbox"/> No follow-up needed for pleural thickening, diaphragmatic tenting, calcified pulmonary nodule(s), calcified lymph node(s), calcified lymph node(s) with calcified pulmonary nodule(s), or minor musculoskeletal findings.

Remarks

Radiologist's Signature _____ Date Interpreted (mm-dd-yyyy) _____

3. Sputum Smears and Cultures

No, not indicated - Applicant has no signs or symptoms of TB, no known HIV infection, and:

- X-ray Normal or 'Other X-Ray Findings' checked above and test for TB infection negative (if performed): this is No Class
- X-ray Normal or 'Other X-Ray Findings' checked above and test for TB infection positive (if performed): this is Class B2 TB, LTBI Evaluation

Yes, are indicated - Applicant has (Mark all that apply):

- Signs or symptoms of TB
- Chest X-ray suggests TB
- HIV infection

<p>Sputum Smear Results</p> <table border="1" style="width:100%"> <thead> <tr> <th>Date Specimen Obtained (mm-dd-yyyy)</th> <th>Positive</th> <th>Negative</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>	Date Specimen Obtained (mm-dd-yyyy)	Positive	Negative										<p>Sputum Culture Results</p> <table border="1" style="width:100%"> <thead> <tr> <th>Date Specimen Obtained (mm-dd-yyyy)</th> <th>Positive</th> <th>Negative</th> <th>NTM*</th> <th>Contaminated</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table> <p style="text-align: center;">* Nontuberculous Mycobacteria</p>	Date Specimen Obtained (mm-dd-yyyy)	Positive	Negative	NTM*	Contaminated															
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Date Specimen Obtained (mm-dd-yyyy)	Positive	Negative	NTM*	Contaminated																													

Positive Smear or Culture Result, or Clinical Judgment: this is a Class A TB

Negative Smear and Culture Results and:

- Chest X-Ray suggests TB: Class B1 TB, Pulmonary
- HIV infection with normal X-ray and no signs and symptoms of TB: No Class for TB



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

For use with DS-2053 or DS-2054

OMB No. 1405-0113
EXPIRATION DATE: 08/31/2014
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.

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

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/ _____
B _____ / _____ (mmHg) Heart rate _____ /min Respiratory rate _____ /min Corrected L 20/ _____ R 20/ _____

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

<table border="0"> <tr><td><input type="checkbox"/> N* <input type="checkbox"/> A* <input type="checkbox"/> ND*</td><td>General appearance and nutritional status</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td><td>Hearing and ears</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td><td>Eyes</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td><td>Nose, mouth, and throat (include dental)</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td><td>Heart (S1, S2, murmur, rub)</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td><td>Breast</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td><td>Lungs</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td><td>Abdomen (including liver, spleen)</td></tr> <tr><td></td><td>Fundal height _____ cm</td></tr> </table>	<input type="checkbox"/> N* <input type="checkbox"/> A* <input type="checkbox"/> ND*	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)		Fundal height _____ cm	<table border="0"> <tr><td><input type="checkbox"/> N* <input type="checkbox"/> A* <input type="checkbox"/> ND*</td><td>Genitalia (including circumcision, infection(s))</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td><td>Inguinal region (including adenopathy)</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td><td>Extremities (including pulses, edema)</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td><td>Musculoskeletal system (including gait)</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td><td>Skin (including hypopigmentation, anesthesia, findings consistent with self-inflicted injury or injections)</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td><td>Lymph nodes</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td><td>Nervous system (including nerve enlargement)</td></tr> <tr><td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td><td>Mental status (including mood, intelligence, perception, thought processes, and behavior during examination)</td></tr> </table>	<input type="checkbox"/> N* <input type="checkbox"/> A* <input type="checkbox"/> ND*	Genitalia (including circumcision, infection(s))	<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 (*Exception: For TB medications, use Part 4 of DS-2053 or DS-2054 form*) _____

For continuing other treatment, specify _____

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

PAPERWORK REDUCTION ACT AND CONFIDENTIALITY STATEMENTS

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VACCINATION DOCUMENTATION WORKSHEET

For Use with DS-2053 or DS-2054

To Be Completed by Panel Physician Only

Name (Last, First, MI.)			Exam Date (mm-dd-yyyy)		REQUIRED FOR U.S. IMMIGRANT VISA APPLICANTS					
					NOT REQUIRED FOR REFUGEE APPLICANTS					
Birth Date (mm-dd-yyyy)		Passport Number		Alien (Case) Number			NOTE FOR PANEL PHYSICIANS: For refugee applicants, please complete only if reliable vaccination documents are available.			

1. Immunization Record					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				
Vaccine History Transferred From a Written Record (List Chronologically from Left to Right)							Not Age Appropriate	Insufficient Time Interval	Contra-indicated	Not Routinely Available	Not Fall (Flu) Season
Vaccine	Date Received (mm-dd-yyyy)	Date Received (mm-dd-yyyy)	Date Received (mm-dd-yyyy)	Date Received (mm-dd-yyyy)							
Specify (check) vaccine: <input type="checkbox"/> DT <input type="checkbox"/> DTP <input type="checkbox"/> DTaP											
Specify (check) vaccine: <input type="checkbox"/> Td <input type="checkbox"/> Tdap											
Specify (check) vaccine: <input type="checkbox"/> Polio -OPV <input type="checkbox"/> IPV											
Specify (check) vaccine: <input type="checkbox"/> MMR (Measles-Mumps-Rubella) <input type="checkbox"/> Rubella											
Specify (check) vaccine: <input type="checkbox"/> Measles											
<input type="checkbox"/> Measles - Rubella											
Specify (check) vaccine: <input type="checkbox"/> Mumps											
<input type="checkbox"/> Mumps - Rubella											
Rotavirus											
Hib											
Hepatitis A											
Hepatitis B											
Meningococcal											
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) _____

PAPERWORK REDUCTION ACT AND CONFIDENTIALITY STATEMENTS

PAPERWORK REDUCTION ACT STATEMENT:

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 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: A/GIS/DIR, Room 2400 SA-22, U.S. Department of State, Washington, DC 20522-2202

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 States 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 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.