MEDICAL EXAMINATION FOR IMMIGRANT OR REFUGEE APPLICANT

Date (mm-dd-yyyy) of Medical Exam

Date (mm-dd-yyyy) of Prior Exam, if any

Exam Place (City/Country)

Panel Physician

Radiology Services

Screening Site (name)

Laboratory Findings (check all boxes that apply):

Syphilis: Not done

Screening

Test name

Date(s) run (mm-dd-yyyy)

Negative

Positive

Titer 1

Notes

Confirmatory

Treated

If treated, therapy:

Yes

Benzathine penicillin, 2.4 MU IM

No

Other (therapy, dose): E

Date(s) treatment given (3 doses for penicillin)

HIV: Not done

Screening

Test name

Date(s) run (mm-dd-yyyy)

Negative

Positive

Indeterminate

Notes

Secondary

Confirmatory

(Formerly OF-157)
**(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")*

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose/Interval <em>(i.e., mg/day)</em></th>
<th>Start Date <em>(mm-dd-yyyy)</em></th>
<th>End Date <em>(mm-dd-yyyy)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Isonaizid (INH)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rifampin</td>
<td></td>
<td></td>
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<tr>
<td>Pyrazinamide</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethambutol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Streptomycin</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Other, specify</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

**For Use with DS-2053**  
Complete Sections 1 through 5, As Applicable  
(See Page 2 - Back of Form)

#### Sections

1. **Chest X-Ray**
   - **(Mark All that Apply)**
     - History of Tuberculosis (TB) Disease
     - Contact with Person with TB
   - **(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.)**

3. **Sputum Smears**
   - **No, Applicant has No Signs or Symptoms of TB and:**
   - **Yes, Applicant has (Mark All that Apply):**

4. **Follow-Up Needed**
   - **No**
   - **Yes**

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

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**Normal Findings**
- Infiltrate or Consolidation
- Any Cavitary Lesion
- Nodule with Poorly Defined Margins (Such as Tuberculoma)
- Pleural Effusion
- Hilar/Mediastinal Adenopathy
- Linear, Interstitial Markings
- Other (Such as Miliary Findings)

**Abnormal Findings**
- Discrete Fibrotic Scar or Linear Opacity
- Discrete Nodule(s) without Calcification
- Discrete Fibrotic Scar with Volume Loss or Retraction
- Discrete Nodule(s) with Volume Loss or Retraction
- Other (Such as Bronchiectasis)

**Follow-Up Needed**
- Musculoskeletal
- Cardiac
- Pulmonary
- Other

**No Follow-Up Needed for**
- Pleural thickening, diaphragmatic tenting, blunting costophrenic angle, solitary calcified nodule or granuloma or minor musculoskeletal or cardiac finding

**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 B1/1B
- OTHER X-Ray Findings Suggest Follow-Up Needed After Arrival, this is Class B

**Follow-Up Needed After**
- **No**
- **Yes**

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

**Name (Last, First, MI.)**: 

**Exam Date (mm-dd-yyyy)**: 

## 1. Immunization Record

Vaccine History Transferred From a Written Record  

<table>
<thead>
<tr>
<th>Vaccine History Incomplete</th>
<th>Completed Series</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blanket Waiver(s) To Be Requested If Vaccination Not Medically Appropriate, Check Suitable Box(es) Below</td>
<td>Not Age Appropriate</td>
</tr>
</tbody>
</table>

### Vaccine History Chronologically from Left to Right

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Date Received (mm-dd-yyyy)</th>
<th>Date Received (mm-dd-yyyy)</th>
<th>Date Received (mm-dd-yyyy)</th>
<th>Date Received (mm-dd-yyyy)</th>
<th>Date Received (mm-dd-yyyy)</th>
<th>Date Received (mm-dd-yyyy)</th>
<th>Date Received (mm-dd-yyyy)</th>
<th>Date Received (mm-dd-yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DT/DTP/DTaP</td>
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<tr>
<td>Polio (OPV/IPV)</td>
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<tr>
<td>Measles (or MR or MMR)</td>
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<tr>
<td>Mumps (or MMR)</td>
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<tr>
<td>Rubella (or MR or MMR)</td>
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<tr>
<td>Rotavirus</td>
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<tr>
<td>Hib (Haemophilus influenzae Type B)</td>
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<td></td>
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<tr>
<td>Hepatitis A</td>
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<tr>
<td>Hepatitis B</td>
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<tr>
<td>Meningococcal</td>
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<tr>
<td>Human papillomavirus</td>
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<tr>
<td>Varicella</td>
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<tr>
<td>Pneumococcal</td>
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<tr>
<td>Influenza</td>
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<td></td>
</tr>
</tbody>
</table>

## 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**:  
- **Signature**:  
- **Date (mm-dd-yyyy)**:  

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**Give Copy to Applicant**

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**U.S. Department of State**

**Vaccination Documentation Worksheet**

**For Use with DS-2053**

**To Be Completed by Panel Physician Only**

**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.

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**OMB No. 1405-0113**

**EXPIRATION DATE: 09/30/2010**

**ESTIMATED BURDEN: 20 minutes**

*(See Page 2 - Back of Form)*

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**Page 1 of 2**
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.

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PAPERWORK REDUCTION ACT NOTICE

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**MEDICAL HISTORY AND PHYSICAL EXAMINATION WORKSHEET**

For use with DS-2053

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### 1. Past Medical History

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Illness or injury requiring hospitalization (including psychiatric)</td>
<td></td>
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</tr>
<tr>
<td>Cardiology Angina pectoris</td>
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<tr>
<td>Hypertension (high blood pressure)</td>
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<tr>
<td>Cardiac arrhythmia</td>
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<tr>
<td>Congenital heart disease</td>
<td></td>
<td></td>
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<tr>
<td>Pulmonology History of tobacco use</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
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</tr>
<tr>
<td>Chronic obstructive pulmonary disease (emphysema)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of tuberculosis (TB) disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiology Angina pectoris</td>
<td></td>
<td></td>
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<tr>
<td>Hypertension (high blood pressure)</td>
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<tr>
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<tr>
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<tr>
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<tr>
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</tr>
<tr>
<td>History of tuberculosis (TB) disease</td>
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<tr>
<td>Use of drugs other than those required for medical reasons</td>
<td></td>
<td></td>
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<tr>
<td>Major impairment in learning, intelligence, self care, memory, or communication</td>
<td></td>
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</tr>
<tr>
<td>Major mental disorder (including major depression, bipolar disorder, schizophrenia, mental retardation)</td>
<td></td>
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</tr>
<tr>
<td>Addiction or abuse of specific substance (drug) <em>amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other substance-related disorders (including alcohol addiction or abuse)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Ever taken action to end your life</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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### 2. Physical Examination

<table>
<thead>
<tr>
<th>Section</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>General appearance and nutritional status</td>
<td></td>
</tr>
<tr>
<td>Hair</td>
<td></td>
</tr>
<tr>
<td>Eyes</td>
<td></td>
</tr>
<tr>
<td>Nose, mouth, and throat (include dental)</td>
<td></td>
</tr>
<tr>
<td>Heart (S1, S2, murm, rub)</td>
<td></td>
</tr>
<tr>
<td>Breast</td>
<td></td>
</tr>
<tr>
<td>Lungs</td>
<td></td>
</tr>
<tr>
<td>Abdomen (including liver, spleen)</td>
<td></td>
</tr>
<tr>
<td>Genitalia (including circumcision, infection(s))</td>
<td></td>
</tr>
<tr>
<td>Extremities (including pulses, edema)</td>
<td></td>
</tr>
<tr>
<td>Skin (including hypopigmentation, anesthesia, findings consistent with self-inflicted injury or injections)</td>
<td></td>
</tr>
<tr>
<td>Lymph nodes</td>
<td></td>
</tr>
<tr>
<td>Nervous system (including nerve enlargement)</td>
<td></td>
</tr>
<tr>
<td>Mental status (including mood, intelligence, perception, thought processes, and behavior during examination)</td>
<td></td>
</tr>
</tbody>
</table>

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

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**U.S. Department of State**

**MEDICAL HISTORY AND PHYSICAL EXAMINATION WORKSHEET**

For use with DS-2053

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**OMB No. 1405-0113**

**EXPIRATION DATE: 09/30/2010**

**ESTIMATED BURDEN: 35 minutes**

(See Page 2 - Back of Form)
3. Additional Testing Needed Prior to Approving Medical Clearance

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Physical examination or laboratory results contradict medical history</td>
</tr>
<tr>
<td></td>
<td>Referral prior to departure If yes, provide results</td>
</tr>
</tbody>
</table>

4. Follow-up Needed After Arrival

<table>
<thead>
<tr>
<th>No</th>
<th>Yes, within 1 week</th>
<th>Yes, within 1 month</th>
<th>Yes, within 6 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>For continuing medication, list type, dose, and frequency</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>For continuing other treatment, specify</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

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