



U.S. Department of State
美国国务院
**MEDICAL EXAMINATION FOR
IMMIGRANT OR REFUGEE APPLICANT**
移民及难民医学检查

OMB NO. 1405 - 0113
EXPIRATION DATE: 1/31/2004
有效截止时间: 2004年1月31日
ESTIMATED BURDEN: 40 minutes
完成表格估计耗时: 40分钟
(See Page 2-Back of Form)
(见第二页)

| | | | |
|---|---|--|---|
| | <p>Name (Last, First, MI) 姓名(姓, 名) _____</p> <p>Birth Date (mm - dd - yyyy) 出生日期(月-日-年) _____</p> <p>SEX: Male Female 性别: <input type="checkbox"/> 男 <input type="checkbox"/> 女</p> <p>Birth Place (City/Country) 出生地(城市/国家) _____ / _____</p> <p>Present Country of Residence _____ Prior Country _____ 现居住国 原居住国</p> <p>U.S. Consul (City/Country) 美领所在地(城市/国家) _____ / _____</p> <p>Passport Number _____ Case Number _____ 护照号码 档案号码</p> <p>Date Exam Expires (6 months from examination date, if Class A or TB condition exists, otherwise 12 months) (mm - dd - yyyy) 体检结果有效截止日期(从体检之日起12个月,若申请人属A级或结核患者,为6个月)(月-日-年) _____</p> <p>Exam Place (City/Country) _____ Panel Physician (name) _____ 体检地点(城市/国家) _____ / _____ 主检医生(姓名) _____</p> <p>Radiology Services (name) _____ Screening Site (name) _____ 影像检查地点(名称) _____ 体检医院(名称) _____</p> <p>Lab (name for HIV/Syphilis/TB) 实验室名称(人类免疫缺陷病毒/梅毒) _____ / _____ / _____</p> | | |
| <p>(1) Classification (Check all boxes that apply): 分类(在相应的方格内打勾)</p> <p><input type="checkbox"/> No apparent defect, disease, or disability (See Worksheets DS-3024, DS-3025 and DS-3026) 无明显损害、疾病或残废(见表 DS-3024, DS-3025 和 DS-3026)</p> | | | |
| <p><input type="checkbox"/> Class A Conditions (From Past medical History and Physical Examination Worksheets) A 级病症 (根据过去史和体检表的内容判断)</p> <table style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <p><input type="checkbox"/> TB, active, infectious (Class A, from Chest X - Ray Worksheet) 活动性结核, 具传染性(据X光胸部检查所见判为A级)</p> <p><input type="checkbox"/> Syphilis, untreated 梅毒, 未治疗</p> <p><input type="checkbox"/> Chancroid, untreated 软下疳, 未治疗</p> <p><input type="checkbox"/> Gonorrhea, untreated 淋病, 未治疗</p> <p><input type="checkbox"/> Granuloma, untreated 腹股沟肉芽肿, 未治疗</p> <p><input type="checkbox"/> Lymphogranuloma venereum, untreated 淋巴肉芽肿, 未治疗</p> </td> <td style="width: 50%; vertical-align: top;"> <p><input type="checkbox"/> Human immunodeficiency virus (HIV) 人类免疫缺陷病毒</p> <p><input type="checkbox"/> Hansen's disease, lepromatous or multibacillary 麻风病, 瘤型或多菌型</p> <p><input type="checkbox"/> Addiction or abuse of specific * substance without harmful behavior 滥用某些特殊物质*, 但尚无有害行为</p> <p><input type="checkbox"/> Any physical or mental disorder (including other substance - related disorder) with harmful behavior or history of such behavior likely to recur 任何心理或精神异常(含其他药物相关的精神异常), 有害行为或历史上曾有有害行为, 现在有可能复发</p> <p><small>* amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative - hypnotics, and anxiolytics * 安非它明, 大麻, 可卡因, 致幻剂, 吸入剂, 鸦片类, 循环苯吡啶, 镇静 - 催眠药和抗焦虑药</small></p> </td> </tr> </table> | | <p><input type="checkbox"/> TB, active, infectious (Class A, from Chest X - Ray Worksheet) 活动性结核, 具传染性(据X光胸部检查所见判为A级)</p> <p><input type="checkbox"/> Syphilis, untreated 梅毒, 未治疗</p> <p><input type="checkbox"/> Chancroid, untreated 软下疳, 未治疗</p> <p><input type="checkbox"/> Gonorrhea, untreated 淋病, 未治疗</p> <p><input type="checkbox"/> Granuloma, untreated 腹股沟肉芽肿, 未治疗</p> <p><input type="checkbox"/> Lymphogranuloma venereum, untreated 淋巴肉芽肿, 未治疗</p> | <p><input type="checkbox"/> Human immunodeficiency virus (HIV) 人类免疫缺陷病毒</p> <p><input type="checkbox"/> Hansen's disease, lepromatous or multibacillary 麻风病, 瘤型或多菌型</p> <p><input type="checkbox"/> Addiction or abuse of specific * substance without harmful behavior 滥用某些特殊物质*, 但尚无有害行为</p> <p><input type="checkbox"/> Any physical or mental disorder (including other substance - related disorder) with harmful behavior or history of such behavior likely to recur 任何心理或精神异常(含其他药物相关的精神异常), 有害行为或历史上曾有有害行为, 现在有可能复发</p> <p><small>* amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative - hypnotics, and anxiolytics * 安非它明, 大麻, 可卡因, 致幻剂, 吸入剂, 鸦片类, 循环苯吡啶, 镇静 - 催眠药和抗焦虑药</small></p> |
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| | | | | | | |
|--|--|---|--------------------------|--|---|----------|
| (2) Laboratory Findings (check all boxes that apply): 实验室检查发现 (在相应的方格内打勾): | | | | | | |
| Syphilis: <input type="checkbox"/> Not done 梅毒: 未做 | | | | | | |
| | Test name 实验项目名称 | Date(s) run (mm-dd-yyyy) 日期(月-日-年) | Negative 阴性 | Positive 阳性 | Titer 1 滴度 1 | Notes 备注 |
| Screening 筛查 | | | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Confirmatory 确认 | | | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Treated 治疗过 <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 | If treated, therapy: 如接受过治疗, 所用疗法: <input type="checkbox"/> Benzathine penicillin, 2.4 MU IM 苄星青霉素 240 万单位, 肌注 <input type="checkbox"/> Other (therapy, does): 其他 (疗法, 剂量): | | | | Dates(s) treatment given (3 doses for penicillin) 给予治疗的日期 (3 次治疗剂量青霉素) | |
| HIV: <input type="checkbox"/> Not done 人类免疫缺陷病毒: 未做 | | | | | | |
| | Test name 实验项目名称 | Date(s) run (mm-dd-yyyy) 日期(月-日-年) | Negative 阴性 | Positive 阳性 | Indeterminate 不确定 | Notes 备注 |
| Screening 筛查 | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Secondary 再查 | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Confirmatory 确认 | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| (3) Immunization (See Vaccination Form, check all boxes that apply) Not required for refugee applicants. 预防接种 (参见预防接种记录表, 在相应方格内打勾), 难民不要求填写此栏目。 | | | | | | |
| <input type="checkbox"/> Vaccine history complete 过去完成接种 <input type="checkbox"/> Vaccine history incomplete, requesting waiver (indicate type below) 过去未完成接种, 符合豁免要求 (以下列形式表述) | | | | | | |
| <input type="checkbox"/> Incomplete vaccine history, no waiver requested 过去未完成接种, 不符合豁免要求 <input type="checkbox"/> Blanket waiver 表中所指豁免项目 <input type="checkbox"/> Individual waiver 个人原因需豁免项目 | | | | | | |
| I certify that I understand the purpose of the medical examination and I authorize the required tests to be completed. 我证明我了解医学检查的目的, 且授权医生完成所要求的检测。 | | | | | | |
| _____ Applicant Signature 申请人签名 | | _____ Panel Physician Signature 主检医生签名 | | _____ Date (mm-dd-yyyy) 日期(月-日-年) | | |

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

文字报告缩减法和个人隐私法之相关通告

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

针对表中的要求对资料进行搜集并根据所得资料完成此表, 估计每份平均需要 40 分钟。若持表人所提交的表上无美国预算和管理局给予的号码, 这类人无需向您提供表中的相关信息。若您对于完成表格所需时间的估计和表格内容的精简有更好的建议, 可告知: 华盛顿特区的国务院所属机构 (A/RPS/DIR), 邮编: 20520-1849

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

我们要求移民签证申请人或难民提供表中所列的内容, 以便于我们确定申请人是否符合移民法第 212(a) 221(d) 或 412(b)(4) 和 (5) 条中的医学要求。如果移民签证或难民身份获得批准, 这份表格将提交到移民局从而将你的情况向疾病控制中心各卫生部通报, 若不按照要求提供个人资料, 你的申请程序将被延迟。若移民签证或难民身份未获批准, 你的表格将依照移民法第 222(f) 条的要求作为密件处理。