Consent Related to Medical Examination for Applicant Using eMedical

I understand that I am required to undergo a complete medical examination pursuant to section 221(d) of the Immigration and Nationality Act (INA), 8 U.S.C. 1201(d), with an authorized physician in order to assess my eligibility consistent with INA Section 212(a)(1), 8 U.S.C. 1182(a)(1). I understand that such an exam is required before I may be issued with an immigrant visa, if I am otherwise eligible to receive such a visa. I understand and consent to my medical examination information (Form DS-7794) being collected and temporarily stored in the eMedical system hosted, operated and maintained by the Australian Department of Home Affairs and being transferred to the U.S. Government for the purposes of enabling a consular officer to determine my medical eligibility and to possibly issue me an immigrant visa, and for the U.S. Centers for Disease Control and Prevention to undertake public health functions under Public Health Services Act Section 325, 42 U.S.C. 252, and INA Section 212(a)(1), 8 U.S.C. 1182(a)(1).

I understand that all immigrant visa applicants 15 years of age and older are required to undergo a chest radiograph (xray) to test for tuberculosis. I understand that if I am pregnant at the time of my initial medical exam, I may refuse the chest radiograph. If I refuse the chest radiograph, I understand that my visa application will not be processed until I have completed the requirement.

I understand that any willfully false or misleading statement or willful concealment of material fact made by me herein may subject me to permanent exclusion from the United States or may subject me to criminal prosecution and/or deportation.

I understand that information provided on my medical examination report may be accessible to other government agencies having statutory or other lawful authority to use such information, including for law enforcement and immigration law enforcement purposes.

I understand the physician will provide me with a copy of my vaccinations and may provide me with lab reports and similar documentation upon my request. The physician will not provide me with copies of the completed U.S. Department of State medical forms.

First and last name of the applicant .

Date (AAAA-MM-DD) :

Signature:_____