

# Immigrant Visa Medical Information

## American Consulate General Chennai

220, Mount Road  
Chennai 600 006  
(downloaded)

Date of initial laboratory exam:

Date of physical examination:

Date of follow-up laboratory tests:

Title: Dr. / Mr. / Mrs. / Ms. / Mast. / Miss

Name:

Address:

Place of birth:

Date of birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Day Month Year

Passport Number:

Please attach  
photograph here.

\_\_\_\_\_  
Signature of the Lab Technologist

\_\_\_\_\_  
Signature of the Applicant

\_\_\_\_\_  
Signature of the Radiographer

The person named above has undergone the laboratory exams at Lister Laboratory and the case reviewed by me.

The person named above has been medically examined by me and my report is submitted on the attached form OF-157.

\_\_\_\_\_  
Signature of the Lab Physician

\_\_\_\_\_  
Signature of the Examining Physician