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B Notifications

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Forms Used in this Section

- [EDN Flowchart](#)
- [EDN Instructions](#)
- [TB Follow-up Worksheet](#)

Introduction

Purpose

Use this section to do the following:

- Follow up on B1, B2 and B3 notifications and
- Evaluate and treat immigrants, refugees and asylees with B1, B2 and B3 notifications.

B1/B2/B3 notifications are sent by the Centers for Disease Control and Prevention (CDC) to the Washington State Tuberculosis (TB) Services as follow-up to overseas screening mandated by US immigration law. The CDC and the Advisory Council for the Elimination of Tuberculosis (ACET) recommend screening high-risk populations for TB, including recent arrivals from areas of the world with a high prevalence of TB. Therefore, screening of foreign-born persons is a public health priority.¹ On the basis of its very high success rate of detecting TB cases, domestic follow-up evaluation of immigrants, refugees and asylees with Class B1, B2 and B3 TB notification status should be given highest priority by all TB control programs.² Legal immigrants, refugees, and asylees with Class B1, B2 and B3 TB notification status are also a high-priority subpopulation for screening for latent TB infection (LTBI).²

The purpose of the medical examination is to identify, for the Department of State and the US Citizenship and Immigration service, applicants with medical conditions of public health concern.³

Not all foreign-born persons who enter the United States go through the same official channels or through the screening process.² For a summary of which groups of foreign-born persons that are screened, refer to Table 1.

TABLE 1: NUMBERS OF FOREIGN-BORN PERSONS WHO ENTERED THE UNITED STATES, BY IMMIGRATION CATEGORY, 2002

Category	Number	Percentage of Total	Screening Required?
Immigrants are defined by the Office of Immigration Statistics (OIS) as persons legally admitted to the United States as permanent residents.	384,000	1.38%	Yes
Refugees and asylees, as defined by OIS, are persons admitted to the United States because they are unable or unwilling to return to their country of nationality due to persecution or a well-founded fear of persecution. Refugees apply for admission at an overseas facility and enter the United States only after their application is granted; asylees apply for admission when already in the United States or at a point of entry.	132,000	0.46%	Yes
Nonimmigrants are aliens granted temporary entry to the United States for a specific purpose (most common visa classifications for nonimmigrants are visitors for pleasure, visitors for business, temporary workers, and students).	27,907,000	98.18%	No
The foreign-born population, as defined by the Census Bureau, refers to all residents of the United States who were not US citizens at birth, regardless of their current legal or citizenship status.	28,423,000	100%	See above
Unauthorized immigrants (also referred to as illegal or undocumented immigrants) are foreign citizens illegally residing in the United States. They include both those who entered without inspection and those who violated the terms of a temporary admission without having gained either permanent resident status or temporary protection from removal.			

Sources: Congress of the United States, Congressional Budget Office. *A Description of the Immigrant Population*. Washington, DC: Congressional Budget Office; November 2004; and ATS, CDC, IDSA. Controlling tuberculosis in the United States: recommendations from the American Thoracic Society, CDC, and the Infectious Diseases Society of America. *MMWR* 2005;54(No. RR-12):46.

In Washington State, between 2008 and 2010, an average of 2,600 refugees arrived each year.⁴

Persons entering in the nonimmigrant category do not require pre-entry screening, but as a condition of entry, persons migrating as immigrants, refugees, and asylees are required to be screened outside of the United States for diseases of public health significance, including TB.⁵ Applicants for immigration who plan to relocate permanently to the United States are required to have a medical evaluation prior to entering the country.

Immigrants coming from several countries with high rates of tuberculosis are being screened according to new 2007 guidelines, see <http://www.cdc.gov/immigrantrefugeehealth/exams/ti/panel/tuberculosis-panel-technical-instructions.html>.

The new guidelines are also being implemented for other high tuberculosis incidence countries. The following table displays applicants for U.S. immigration being screened according to the 2007 Technical Instructions for Tuberculosis Screening and Treatment by country, population, and start date as of January 23, 2009.

TABLE 2: APPLICANTS SCREENED ACCORDING TO 2007 TECHNICAL INSTRUCTIONS BY COUNTRY

Country	Population	Start date
Bangladesh	All applicants	June 15, 2011
Botswana	All applicants	March 3, 2008
Cambodia	All applicants	February 1, 2010
China	All applicants	July 1, 2009
Colombia	All applicants	August 15, 2011
Dominican Republic	All applicants	February 2, 2009
Egypt	All applicants	November 15, 2009
Ethiopia	Refugees (Eritreans)	March 10, 2009
	All applicants	April 1, 2009
Ghana	All applicants	October 1, 2010
Guatemala	All applicants	May 2, 2011
Haiti	All applicants	September 26, 2009
Hong Kong SAR	All applicants	November 3, 2008
India	All applicants	October 1, 2010
Japan	All applicants	June 1, 2009
Jordan	All applicants	April 5, 2009
Kenya	Refugees (includes Ethiopians, Somalis, and Sudanese)	January 1, 2008
	All applicants	April 1, 2009
Lesotho	All applicants	March 3, 2008
Macau SAR	All applicants	November 3, 2008
Malaysia	Refugees (Burmese)	January 1, 2009
Mexico	All applicants	October 1, 2007
Mozambique	All applicants	March 3, 2008
Namibia	All applicants	March 3, 2008
Nepal	Refugees (Bhutanese)	December 13, 2007
	All applicants	August 2, 2010
Nigeria	All applicants	October 1, 2010
Philippines	All applicants	October 1, 2007
South Africa	All applicants	March 3, 2008
South Korea	All applicants	May 2, 2011
Swaziland	All applicants	March 3, 2008
Taiwan	All applicants	April 1, 2009
Tanzania	Refugees (Burundian)	January 1, 2008
	All applicants	June 5, 2008
Thailand	Refugees (includes Burmese and Hmong refugees)	April 9, 2007
	All applicants	April 25, 2011
Turkey	All applicants	February 4, 2008
Uganda	All applicants	March 2, 2009
Vietnam	All applicants	February 1, 2008

Refer to <http://www.cdc.gov/immigrantrefugeehealth/exams/ti/panel/tuberculosis-implememtation.html> for current information.

All other applicants for U.S. immigration are still being screened according to the 1991 Tuberculosis Technical Instructions, available at <http://www.cdc.gov/immigrantrefugeehealth/exams/ti/panel/technical-instructions-panel-physicians.html>.

Under the 1991 Guidelines, applicants who are identified as having abnormalities in their chest radiographs consistent with TB are classified according to the criteria in Table 3. An applicant whose chest radiograph is compatible with active TB, but whose sputum AFB smear results are negative, is classified as having Class B1 status and may enter the United States. If the chest radiograph is compatible with inactive TB, no sputum specimens are required, and the applicant may enter the country with Class B2 status. If abnormalities are present in a chest radiograph and sputum AFB smears are positive, the applicant must receive a Class A waiver before entry into the United States. Very few persons with A waivers enter the United States, so A waivers are not covered in these guidelines.

The Class B notification system continues follow-up on medical screenings of persons with B1 and B2 classifications after their arrival in the United States. Immigrants with a Class A waiver or with Class B1 or B2 status are identified at ports of entry to the United States by the US Citizenship and Immigration Services (USCIS) and reported to CDC's Division of Global Migration and Quarantine (DGMQ). The DGMQ notifies Washington State Department of Health TB Services of refugees, immigrants and asylees with TB classifications who are moving to their jurisdiction and need follow-up evaluations. Persons with a Class A waiver are required to report to the local jurisdictional public health agency for evaluation, or risk deportation. For persons with Class B1 and B2 status, however, the stipulated evaluation visits to the health agency are voluntary.²

TABLE 3: 1991 CLASSIFICATION OF IMMIGRANTS AND REFUGEES IN THE B NOTIFICATION PROGRAM

Immigrant/ Refugee Classification	Overseas Chest Radiograph	Overseas Sputum Acid-Fast Bacilli Smears	Restrictions
A Waiver*	Abnormal, suggestive of active tuberculosis (TB) disease	Positive	May not enter the United States unless started on antituberculosis therapy with sputum smears converted to negative and: <ul style="list-style-type: none"> ▪ Apply for a waiver signed by the local health jurisdiction at their intended US destination (A Waiver) or <ul style="list-style-type: none"> ▪ Complete TB therapy overseas
B1	Abnormal, suggestive of	Negative	Instructed to voluntarily report to the local health jurisdiction in the United

	active TB disease		States for further medical evaluation within 30 days of arrival
B2	Abnormal, suggestive of inactive TB disease	Negative	Same as above
* Very few persons with A waivers enter the United States, so they are excluded from these guidelines.			

Source: California Department of Health Services (CDHS)/California Tuberculosis Controllers Association (CTCA). Guidelines for the follow-up and assessment of persons with Class B1/B2 tuberculosis. *CDHS/CTCA Joint Guidelines* [CTCA Web site]. September 1999:1. Available at: http://www.ctca.org/fileLibrary/file_54.pdf

The criteria for assigning screening categories in the new 2007 classification system are shown in Table 4.

TABLE 4: 2007 CLASSIFICATION SYSTEM

No TB Classification	Applicants with normal tuberculosis screening examinations.
Class A TB with waiver	All applicants who have tuberculosis disease and have been granted a waiver.
Class B1 TB, Pulmonary	<p>No treatment</p> <ul style="list-style-type: none"> Applicants who have medical history, physical exam, HIV, or CXR findings suggestive of pulmonary tuberculosis but have negative AFB sputum smears and cultures and are not diagnosed with tuberculosis or can wait to have tuberculosis treatment started after immigration. <p>Completed treatment</p> <ul style="list-style-type: none"> Applicants who were diagnosed with pulmonary tuberculosis and successfully completed directly observed therapy prior to immigration. The cover sheet should indicate if the initial sputum smears and cultures were positive and if drug susceptibility testing results are available.
Class B1 TB, Extrapulmonary	Applicants with evidence of extrapulmonary tuberculosis. Document the anatomic site of infection.
Class B2 TB, LTBI Evaluation	Applicants who have a tuberculin skin test ≥ 10 mm but otherwise have a negative evaluation for tuberculosis. The size of the TST reaction, the applicant's status with respect to LTBI treatment, and the medication(s) used should be documented. For applicants who had more than one TST, whether the applicant converted the TST should be documented (i.e., initial TST < 10 mm but subsequent TST ≥ 10 mm).
Class B3 TB, Contact Evaluation	Applicants who are a recent contact of a known tuberculosis case. The size of the applicant's TST reaction should be documented. Information about the source case, name, alien number, relationship to contact, and type of tuberculosis should also be documented.

Source: Centers for Disease Control and Prevention (CDC) Division of Global Migration and Quarantine (DGMQ). "CDC Immigration Requirements: Technical Instructions for Tuberculosis Screening and Treatment, 2007." Available at <http://www.cdc.gov/immigrantrefugeehealth/exams/ti/panel/tuberculosis-panel-technical-instructions.html>

Significant changes in the 2007 Technical Instructions for Tuberculosis Screening include requiring:

- Tuberculin skin tests (TST) for applicants <15 years of age in countries with a World Health Organization (WHO)-estimated tuberculosis incidence rate >20 per 100,000.
- A chest radiograph for all applicants <15 years of age with TST \geq 5 mm. Mycobacterial cultures for applicants with chest radiographs suggestive of tuberculosis disease.
- Treatment under a directly observed therapy (DOT) program.
- Completion of treatment prior to immigrating to the United States, according to American Thoracic Society/CDC/Infectious Diseases Society of America guidelines.
- New TB classifications for all applicants with suspected latent *Mycobacterium tuberculosis* infection and for contacts for cases of tuberculosis disease.

A detailed comparison on the 1991 and 2007 Technical Instructions is available at <http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/tuberculosis-guidelines.html#table1>



The guideline for diagnosis of LTBI is still a TST of greater than or equal to 10 mm of induration. However, the trigger for a chest radiograph for persons being evaluated under the 2007 technical instructions is 5 mm of induration.

Policy

Newly arrived immigrants, refugees and asylees with Class B1/B2/B3 TB will receive thorough and timely TB evaluations and appropriate treatment to ensure prompt detection of TB disease and prevention of future cases.

Follow-up of B1, B2, and B3 Tuberculosis Arrivals

Division of Global Migration and Quarantine Forms

The Centers for Disease Control and Prevention (CDC) Division of Global Migration and Quarantine (DGMQ) generates the following Class B notification forms:

- [Follow-up Worksheet](#)
- DS-2053: “Medical Examination for Immigrant or Refugee Application”
- DS-3024: “Chest Radiograph and Classification Worksheet”

The DGMQ sends the notifications to Washington State Department of Health Tuberculosis Services. The DGMQ also sends a letter to any immigrant, refugee or asylee with a tuberculosis (TB) condition, indicating that a follow-up is needed in the United States.

The Washington State Department of Health Tuberculosis Services notifies local health jurisdictions of arrivals by forwarding the B1/B2/B3 notifications to the county designated as the intended residence of the immigrant, refugee or asylee.

Electronic Disease Notification Process Overview

[EDN Process Flowchart](#)

The Washington State Department of Health receives notification of newly arrived immigrants, refugees and asylees electronically from the Centers for Disease Control and Prevention through the Electronic Disease Notification (EDN) system. Records from overseas medical examinations are downloaded and sent to local health jurisdictions or their designated local screening agencies.

The local health jurisdiction completes the evaluation of the new arrival and returns a completed [Follow-Up Worksheet](#) to the Department of Health via fax or mail. Follow-up worksheets should be submitted to DOH (1) No later than 90 days from arrival date into the United States and (2) When therapy for active disease or latent tuberculosis infection is completed.

If the local health jurisdiction is unable to locate the new arrival, the new arrival has moved, or they fail to come to scheduled appointments; the paperwork is returned to the Department of Health with an explanation as to why the evaluation was unable to be completed.

At the Department of Health a designated staff member enters data from returned Follow-up Worksheets into the Electronic Disease Notification database and submits it to the Centers for Disease Control and Prevention. This data assists in tracking the progress of [National/State Objectives & Measures](#).

Notes:

1. When contacting the Department of Health about the status of a new arrival where paperwork has not been received yet from the Electronic Disease Notification system, please use the person's alien number and date of entry into the United States in all correspondence. This information is needed to track individuals within the system.

Patient Follow-up



The immigration paperwork may make it appear that a patient has had a complete evaluation for TB disease. However, under the 1991 guidelines, the overseas evaluation is designed only to detect abnormal radiographs and to determine *infectiousness* at the time of travel. The evaluation does not rule out TB disease. Under the 2007 guidelines, a more thorough evaluation is done overseas. However, individuals may enter the United States with “non-infectious” tuberculosis disease, such as extrapulmonary tuberculosis. All B1 and B2 arrivals under the 1991 guidelines need a new diagnostic evaluation for active disease, including a tuberculin skin test or IGRA test, a new chest radiograph and sputum cultures if symptomatic or chest radiograph indicative of tuberculosis. Even if active TB disease is ruled out, most B1 and B2 arrivals are priority candidates for treatment of latent TB infection (LTBI). Under the 2007 guidelines, B1 arrival evaluation is the same (except AFB cultures as well as smears are obtained) B2 arrivals need to be evaluated for LTBI as do B3 arrivals who are contacts to cases in their country of origin.

Suggested follow-up of each B1, B2 or B3 arrival is described below. (The term “Immigrant” used in the rest of this document includes all three categories: immigrants, refugees and asylees)

1. Determine if the immigrant has already visited the health department.
2. If not, make a telephone call to the home of the immigrant’s sponsor or relative after receiving the notification. Arrange for the immigrant to come in during clinic hours at the health department and/or arrange for the patient to see a private provider.
3. If the immigrant does not visit the health department or a private provider after the telephone call, send a letter to the home of the immigrant’s sponsor or relative.
4. If the immigrant does not visit the health department or a private provider after receiving the letter, visit the home of the immigrant’s sponsor or relative. If indicated, bring with you a representative who speaks the immigrant’s first language, if at all possible.
5. Every effort should be made to locate B1, B2 and B3 arrivals as these immigrants are considered high risk for TB disease.
6. Complete the Class B follow-up.
7. Complete and return the B notification Follow-up form to Washington State TB Services. This form is essential for Washington State TB Services to conduct statewide surveillance and follow-up on all B1, B2 and B3 arrivals and report the results to the CDC.



For more information on screenings, the Spokane Regional Health District provides an example of a [Refugee Program Manual](#).

Evaluation of B1 and B2 Tuberculosis Arrivals

Evaluation Activities

Upon receipt of immigration paperwork, the local health jurisdiction needs to look at what country the immigrant comes from to determine whether they have been screened according to the 1991 or 2007 Technical Instructions. If unsure whether the country of origin is under the new Technical Instructions, go to <http://www.cdc.gov/immigrantrefugeehealth/exams/ti/panel/tuberculosis-implementation.html> for a current list.

Arrivals from countries still under the 1991 Guidelines:

B1 arrivals had overseas sputum samples that were negative for acid-fast bacilli on smear and overseas chest radiographs that are abnormal and suggestive of **active TB disease**

B2 arrivals had overseas sputum samples that were negative for acid-fast bacilli on smear and overseas chest radiographs that are abnormal and suggestive of **inactive TB disease**.

Refer to Tables 6 and 7 to determine which evaluation tasks should be done for B1, B2 and B3 arrivals.

Table 5: Evaluation Activities for B1 and B2 Arrivals 1991 Guidelines

Evaluation Activities	B1 Active TB	B2 Inactive TB
<ul style="list-style-type: none"> Determine tuberculin skin test (TST) status. If documentation is not available, administer a TST. A reaction of ≥ 5 mm is considered significant for persons with an abnormal chest radiographs. Screening may also be done using the IGRA blood test. 	Yes	Yes
<ul style="list-style-type: none"> Review the chest radiograph.. Even if patients have their overseas chest radiographs available, a new chest radiograph must be taken. 	Yes	Yes
<ul style="list-style-type: none"> Review TB treatment history with the patient. Treatment history may be on the visa medical examination report form DS-2053: <i>Medical Examination for Immigrant or Refugee Application</i>. In some cases, patients have received treatment not documented on the DS-2053. Regardless of the chest radiograph result, collect sputum specimens if the patient is symptomatic. 	Yes	Yes
<ul style="list-style-type: none"> Collect sputum for testing. Sputum specimens should be collected 8 to 24 hours apart, with at least one being an early morning specimen. Regardless of the chest radiograph result, collect sputum specimens if the patient is symptomatic. 	Yes	If symptoms present

Sources: Curry International Tuberculosis Center. Recommended TB clinic procedures for Class B1 TB arrivals and recommended TB clinic procedures for Class B2 TB arrivals. In: Text: step-by-step guide. *B Notification Assessment and Follow-up Toolbox* [Curry International Tuberculosis Center Web site]. San Francisco, CA; January 2004.

TABLE 6: EVALUATION ACTIVITIES FOR B1, B2 AND B3 ARRIVALS UNDER 2007 GUIDELINES⁶

Evaluation Activities	B1 Active/Inactive TB	B2 LTBI	B3 Contacts
<ul style="list-style-type: none"> Determine tuberculin skin test (TST) status. If documentation is not available, administer a TST. A reaction of ≥ 5 mm is considered significant for persons with an abnormal chest radiograph. 	Yes	Yes	Yes
<ul style="list-style-type: none"> Review the chest radiograph. Even if patients have their overseas chest radiographs available, a new chest radiograph must be taken. 	Yes	Yes, if TST positive	Yes, if TST positive
<ul style="list-style-type: none"> Review TB treatment history with the patient. Treatment history may be on the visa medical examination report, form DS-2053: <i>Medical Examination for Immigrant or Refugee Application</i>. In some cases, patients have received treatment not documented on the DS-2053. 	Yes	Yes	Yes
<ul style="list-style-type: none"> Collect sputum for testing. Sputum specimens should be collected 8 to 24 hours apart, with at least one being an early morning specimen. 	Yes	If symptoms present	If symptoms present

Sources: Curry International Tuberculosis Center. Recommended TB clinic procedures for Class B1 TB arrivals and recommended TB clinic procedures for Class B2 TB arrivals. In: Text: step-by-step guide. *B Notification Assessment and Follow-up Toolbox* [Curry International Tuberculosis Center Web site]. San Francisco, CA; January 2004.

Documentation

The Follow-up Worksheet will be sent to the local health jurisdiction with the overseas medical evaluation information for each immigrant. It will be filled in manually by the medical provider, then entered into the Electronic Disease Notification (EDN) system by DOH staff.



The following form assists in completing the Follow-up Form:

[DOH Instructions for completing Follow-up Form](#)

Forms also available in the **FORMS** section of the manual.

Treatment

Prescribe medications as appropriate. ***Do not start patients on single-drug therapy for latent TB infection (LTBI) until tuberculosis (TB) disease is ruled out.*** B1/B2/B3 immigrants with positive tuberculin skin tests or IGRA tests for whom active TB has been ruled out are priority candidates for treatment of LTBI because of the increased probability of recent infection and subsequent progression to active TB disease. Patients with fibrotic lesions on a chest radiograph suggestive of old, healed TB are candidates for treatment of LTBI, regardless of age.



The overseas diagnosis of clinically active TB disease under the 1991 guidelines is based upon the abnormal chest radiograph. Reevaluation in the United States may show the patient to actually have old, healed TB. According to current CDC/American Thoracic Society (ATS) recommendations, old, healed TB can be treated with four months of isoniazid and rifampin or with nine months of isoniazid.²



For more information on treatment, see the Centers for Disease Control and Prevention *Targeted Tuberculin Testing and Treatment of Latent Tuberculosis Infection* (MMWR June 9, 2000/vol 49/RR-6) at <http://www.cdc.gov/mmwr/PDF/rr/rr4906.pdf>

Resources and References

Resources

- California Department of Health Services (CDHS)/California Tuberculosis Controllers Association (CTCA). “Guidelines for the Follow-up and Assessment of Persons with Class B1/B2 Tuberculosis” (*CDHS/CTCA Joint Guidelines*; September 1999). Available at: http://www.ctca.org/fileLibrary_54.pdf .
- Centers for Disease Control and Prevention (CDC) Division of Global Migration and Quarantine (DGMQ). “Medical Examinations of Aliens (Refugees and Immigrants)” (CDC Web site; accessed September 25, 2006). Available at: <http://www.cdc.gov/ncidod/dq/health.htm> .
- Centers for Disease Control and Prevention (CDC) Division of Global Migration and Quarantine (DGMQ). “CDC Immigration Requirements: Technical Instructions for Tuberculosis Screening and Treatment, 2007.” Available at <http://www.cdc.gov/immigrantrefugeehealth/exams/ti/panel/tuberculosis-panel-technical-instructions.html>
- Centers for Disease Control and Prevention (CDC) Division of Global Migration and Quarantine (DGMQ). Comparison of 2007 Technical Instructions for Tuberculosis Screening and Treatment with 1991 Instructions. Available at <http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/tuberculosis-guidelines.html#table1>
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- ¹ California Department of Health Services (CDHS)/California Tuberculosis Controllers Association (CTCA). Guidelines for the follow-up and assessment of persons with Class B1/B2 tuberculosis. *CDHS/CTCA Joint Guidelines* [CTCA Web site]. September 1999:1. Available at: http://www.ctca.org/fileLibrary_54.pdf .
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- ⁴ Martin, C. and Hoefler, M. Homeland Security: Office of Immigration Statistics. Annual Flow Report: Refugees and Asylees: 2010. (May 2011). Available at http://www.dhs.gov/xlibrary/assets/statistics/publications/ois_rfa_fr_2010.pdf
- ⁵ CDC. CDC Immigration Requirements: Technical Instructions for Tuberculosis Screening and Treatment 2007. Available at <http://www.cdc.gov/immigrantrefugeehealth/exams/ti/panel/tuberculosis-panel-technical-instructions.html>