Report of Medical Examination and Vaccination Record

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-693
OMB No. 1615-0033
Expires 02/28/2019

► **START HERE - Type or print in black ink.**

Part 1. Information About You (To be completed by the person requesting a medical examination, **NOT** the civil surgeon)

1. Your Full Name

Family Name (Last Name) | Given Name (First Name) | Middle Name

2. Physical Address

Street Number and Name | Apt. Ste. Flr. | Number

City or Town | State | ZIP Code

3. Other Information

A. Sex ☐ Male ☐ Female

B. Date of Birth (mm/dd/yyyy)

C. City/Town/Village of Birth

D. Country of Birth

E. Alien Registration Number (A-Number) (if any)
► **A-**

F. USCIS Online Account Number (if any)
►

Part 2. Applicant's Statement, Contact Information, Certification, and Signature

NOTE: Read the **Penalties** section of the Form I-693 Instructions before completing this Part. You must submit Form I-693 in a sealed envelope to USCIS as directed in the Form I-693 Instructions.

Applicant's Statement

NOTE: Select the box for either **Item A.** or **B.** in **Item Number 1.**

1. Applicant's Statement Regarding the Interpreter

A. ☐ I can read and understand English, and I have read and understand every question and instruction on this form and my answer to every question.

B. ☐ The interpreter named in **Part 3.** read to me every question and instruction on this form and my answer to every question in _____, a language in which I am fluent, and I understood everything.

Applicant's Contact Information

2. Applicant's Daytime Telephone Number

3. Applicant's Mobile Telephone Number (if any)

4. Applicant's Email Address (if any)

Family Name (Last Name)	Given Name (First Name)	Middle Name	A-Number (if any)
			► A-

Part 2. Applicant's Statement, Contact Information, Certification, and Signature (continued)

Applicant's Certification

I authorize the release of any information from any of my records that USCIS may need to determine my eligibility for the immigration benefit I seek.

I further authorize release of information contained in this form, in supporting documents, and in my USCIS records to other entities and persons where necessary for the administration and enforcement of U.S. immigration laws.

I understand that USCIS may require me to appear for an appointment to take my biometrics (fingerprints, photograph, and/or signature) and, at that time, if I am required to provide biometrics, I will be required to sign an oath reaffirming that:

1) I reviewed and provided or authorized all of the information in my form;

2) I understood all of the information contained in, and submitted with, my form; and

3) All of this information was complete, true, and correct at the time of filing.

I certify, under penalty of perjury that I am the person who is identified in **Part 1.** of this Form I-693, and that the information in **Part 1.** of this form is complete, true, and correct. I understand the purpose of this medical examination, and I authorize the required tests and procedures to be completed. If it is determined that I willfully misrepresented a material fact or provided false or altered information or documents with regard to my medical examination, I understand that any immigration benefit I derived from this medical examination may be revoked, that I may be removed from the United States, and that I may be subject to civil or criminal penalties.

Applicant's Signature

NOTE: Do not sign or date Form I-693 until instructed to do so by the civil surgeon.

5. Applicant's Signature ➡ _____ Date of Signature (mm/dd/yyyy) _____

NOTE TO ALL APPLICANTS AND CIVIL SURGEONS: If you or the civil surgeon do not completely fill out this form according to the instructions USCIS may deny your immigration benefit.

Part 3. Interpreter's Contact Information, Certification, and Signature

Provide the following information about the interpreter.

Interpreter's Full Name

1. Interpreter's Family Name (Last Name) _____ Interpreter's Given Name (First Name) _____

2. Interpreter's Business or Organization Name (if any) _____

Family Name (Last Name)	Given Name (First Name)	Middle Name	A-Number (if any)
			► A-

Part 3. Interpreter's Contact Information, Certification, and Signature (continued)

Interpreter's Mailing Address

3. Street Number and Name

Apt. Ste. Flr. Number

City or Town

State ZIP Code

Province

Postal Code

Country

Interpreter's Contact Information

4. Interpreter's Daytime Telephone Number

5. Interpreter's Mobile Telephone Number (if any)

6. Interpreter's Email Address (if any)

Interpreter's Certification

I certify, under penalty of perjury, that:

I am fluent in English and _____, which is the same language specified in **Part 2.**, **Item B.** in **Item Number 1.**, and I have read to this applicant in the identified language every question and instruction on this form and his or her answer to every question. The applicant informed me that he or she understands every instruction, question, and answer on the form, including the **Applicant's Certification**, and has verified the accuracy of every answer.

Interpreter's Signature

7. Interpreter's Signature

Date of Signature (mm/dd/yyyy)

Parts 4. - 9. of this form must be completed by the civil surgeon.

Part 4. Applicant's Identification Information (To be completed by the civil surgeon)

Please complete the following about the applicant:

1. Form of identification presented by applicant (for example, passport or driver's license)

2. Document Identification Number

Family Name (Last Name)	Given Name (First Name)	Middle Name	A-Number (if any)
			► A-

Part 5. Summary of Medical Examination (To be completed by the civil surgeon)

1. Summary of Overall Findings:

A. ☐ No Class A or Class B Condition

B. ☐ Class B Conditions (See **Item Numbers 1. - 4.** in **Part 7. Civil Surgeon Worksheet**)

C. ☐ Class A Conditions (See **Item Numbers 1. - 3.** in **Part 7. Civil Surgeon Worksheet**)

2. Date of First Examination
(mm/dd/yyyy)

3. Dates of Follow-up Examinations, if required:

Date of Examination (mm/dd/yyyy)

Date of Examination (mm/dd/yyyy)

Date of Examination (mm/dd/yyyy)

Part 6. Civil Surgeon's Contact Information, Certification, and Signature

NOTE: Do not sign Form I-693 and do not have the applicant sign in **Part 2.** until all health-related follow-up requirements are met.

Civil Surgeon's Information

1. Family Name (Last Name) | Given Name (First Name) | Middle Name (if applicable)

2. Name of Medical Practice, Facility, or Health Department

Physical Address

3. Street Number and Name | Apt. Ste. Flr. | Number

City or Town | State | ZIP Code

Mailing Address

4. Street Number and Name (PO Box) | Apt. Ste. Flr. | Number (if applicable)

City or Town | State | ZIP Code

Contact Information

5. Daytime Telephone Number

6. Mobile Telephone Number (if any)

7. Email Address (if any)

Family Name (Last Name)	Given Name (First Name)	Middle Name	A-Number (if any)
			► **A-**

Part 6. Civil Surgeon's Contact Information, Certification, and Signature (continued)

Civil Surgeon's Certification

I certify under penalty of perjury under United States law that:

I am a civil surgeon designated to examine applicants seeking certain immigration benefits in the United States OR a physician who qualifies under a blanket designation specified by policy or law;

I have a currently valid and unrestricted license to practice medicine in the state where I am performing immigration-related medical examinations, unless otherwise exempted;

I have not had my license to practice medicine revoked, and I am not subject to any restrictions on any license to practice medicine in any other jurisdiction in the United States in which I conduct immigration-related medical examinations.

I performed an examination of the person identified in **Part 1.** of this Form I-693, after having made every reasonable effort to verify that the person whom I examined is in fact the person identified in **Part 1.**;

I performed the examination in accordance with the Centers for Disease Control and Prevention's (CDC) *Technical Instructions*, as well as all supplemental information or updates; and

All the information I provided on this Form I-693 is complete, true, and correct, based on the information provided to me by the applicant.

Civil Surgeon's Signature

8. Civil Surgeon's Signature

Date of Signature (mm/dd/yyyy)

(Health departments and military treatment facilities MUST place their official stamp or seal here)

(official stamp or seal here)

Family Name (Last Name)	Given Name (First Name)	Middle Name	A-Number (if any)
			▶ A-

Part 7. Civil Surgeon Worksheet

(To be completed by the civil surgeon, according to the Technical Instructions at **www.cdc.gov/immigrantrefugeehealth/exams/ti/civil/technical-instructions-civil-surgeons.html**)

1. Communicable Disease of Public Health Significance

A. Tuberculosis (TB): An initial screening test, either a tuberculin skin test (TST) or an interferon gamma release assay (IGRA), is required for all applicants 2 years of age and older; for children under 2 years of age, see the *Technical Instructions*. The civil surgeon should perform only **one type of initial screening test**, followed by further evaluation if needed (chest X-ray).

(1) Tuberculin Skin Test:

☐ Not administered (TST exception; please explain in Remarks section below)

Date TST Applied (mm/dd/yyyy) | Date TST Read (mm/dd/yyyy) | Size of Reaction (mm)

Result: ☐ Negative (4mm or less of induration) ☐ Positive (≥ 5mm; chest X-ray required)

(2) Interferon Gamma Release Assay (for acceptable IGRA's, consult the *Technical Instructions* and any updates posted on the CDC's website):

☐ Not administered (IGRA exception; please explain in Remarks section below)

Select **only one** box.

☐ QuantiFERON ☐ T-Spot

Date Blood Sample Drawn (mm/dd/yyyy) | Date Blood Sample Drawn (mm/dd/yyyy)

Result: ☐ Negative (including indeterminate, or borderline/equivocal) (no chest X-ray required)

☐ Positive (chest X-ray required)

☐ Indeterminate, borderline, or equivocal) (no chest X-ray required)

(3) Initial Screening Test Result and Chest X-Ray Determinations:

☐ Chest X-ray not required (medically cleared for TB for USCIS)

☐ Chest X-ray required due to initial screening test results

☐ Chest X-ray required due to TB signs or symptoms, or due to immunosuppression (such as HIV)

☐ Chest X-ray required due to TST or IGRA exception (Clearly specify the TST or IGRA exception in the Remarks section below.)

(4) Chest X-Ray: Required based on TST or IGRA result, or if specific TST or IGRA exceptions apply, or for an applicant with TB signs or symptoms or immunosuppression (such as HIV).

Date Chest X-Ray Taken (mm/dd/yyyy) | Date Chest X-Ray Read (mm/dd/yyyy)

Result: ☐ Normal ☐ Abnormal (describe results in Remarks section below.)

TB Classification/Findings (Select only if chest X-ray was performed):

☐ No Class A or Class B TB

☐ Class A Pulmonary TB Disease

☐ Class B1 Extra Pulmonary TB

☐ Class B1 Pulmonary TB

☐ Class B2 Pulmonary TB

☐ Class B, Other Chest Condition (non-TB)

☐ Class B, Latent TB Infection (Answer the following question.)

Was applicant referred for treatment (not required to complete Form I-693)? ☐ Yes ☐ No

Family Name (Last Name)	Given Name (First Name)	Middle Name	A-Number (if any)
			► A-

Part 7. Civil Surgeon Worksheet (continued)

(5) Remarks: (Include any signs or symptoms of TB, additional tests and therapy given, with start and stop dates and any changes. If you did not perform TST or IGRA, give the reason why an exception applies.)

B. Syphilis

(1) Serologic Test for Syphilis (Required for applicants 15 years of age and older)

(a) Name of Screening Test

(b) Date Screening Run (mm/dd/yyyy)

(c) ☐ Screening Nonreactive (mm/dd/yyyy)

☐ Screening Reactive, Titer 1:

(d) If Reactive, Name of Confirmatory Test

(e) Date Confirmation Run (mm/dd/yyyy)

(f) ☐ Confirmation Nonreactive ☐ Confirmation Reactive

(2) Findings:

☐ No Class A or Class B Syphilis ☐ Syphilis, Class A (untreated) ☐ Syphilis, Class B (treated in the last year)

(3) Remarks: (Include any therapy given with doses and dates)

Drug: Dosage:

Start Date (mm/dd/yyyy) End Date (mm/dd/yyyy)

C. Gonorrhea

(1) Laboratory Test for Gonorrhea (Required for applicants 15 years of age and older)

(a) Screening Test Name

(b) Date Specimen Reported (mm/dd/yyyy)

(c) ☐ Positive ☐ Negative

Family Name (Last Name)	Given Name (First Name)	Middle Name	A-Number (if any)
			► A-

Part 7. Civil Surgeon Worksheet (continued)

(2) Findings:

☐ No Class A or Class B Gonorrhea ☐ Gonorrhea, Class A (untreated)

☐ Gonorrhea, Class B (treated in the last year)

(3) Remarks: (Include any treatment given with doses and dates)

Drug: Dosage:

Start Date (mm/dd/yyyy) End Date (mm/dd/yyyy)

D. Other Class A/Class B Conditions for Communicable Diseases of Public Health Significance

(1) Findings:

(a) ☐ No Class A/B Condition

(b) ☐ Hansen's Disease (leprosy, any classification) untreated, Class A

☐ Indeterminate, tuberculoid, borderline tuberculoid (paucibacillary)

☐ Mid-borderline, borderline lepromatous, lepromatous (multibacillary)

(c) ☐ Hansen's Disease (leprosy, any classification) treated or partially treated, Class B

☐ Indeterminate, tuberculoid, borderline tuberculoid (paucibacillary)

☐ Mid-borderline, borderline lepromatous, lepromatous (multibacillary)

(2) Remarks: (Include any therapy given and any counseling or referrals) If you need extra space to complete this section, use the space provided in **Part 10. Additional Information**.

2. Physical or Mental Disorders With Associated Harmful Behavior

Include here any physical or mental disorders with current associated harmful behavior or history of associated harmful behavior judged likely to recur. This category of physical or mental disorders includes any diagnosis of substance-related disorders that involve any substance that is not listed in Schedule I, II, III, IV, or V of section 202 of the Controlled Substances Act (for example, diagnosis of an alcohol-related disorder). Diagnose mental disorders according to the diagnostic criteria in the most recent edition of the Diagnostic and Statistical Manual (DSM) or another authoritative source, as determined by the director of the CDC. Diagnose physical disorders according to the diagnostic criteria in the most recent edition of the World Health Organization's Manual of the International Classification of Diseases, Injuries, and Causes of Death (ICD) or another authoritative source as determined by the director of the CDC. See the CDC's Technical Instructions for more information.

A. Findings:

(1) ☐ No Class A or B Physical or Mental Disorder

(2) ☐ Current Physical/Mental Disorder with Associated Harmful Behavior, Class A

(3) ☐ History of Physical/Mental Disorder with Associated Harmful Behavior Likely to Recur, Class A

(4) ☐ Current Physical/Mental Disorder without Associated Harmful Behavior, Class B

(5) ☐ History of Physical/Mental Disorder with Associated Harmful Behavior Unlikely to Recur, Class B

Family Name (Last Name)	Given Name (First Name)	Middle Name	A-Number (if any)
			► A-

Part 7. Civil Surgeon Worksheet (continued)

B. Remarks: (Include diagnosis, likelihood of recurrence of the harmful behavior, therapy given, and any counseling or referrals. If you need extra space to complete this section, use the space provided in **Part 10. Additional Information**.

3. Drug Abuse/ Drug Addiction

The U.S. Department of Health and Human Services (DHHS) sets the medical guidelines for determining drug abuse and drug addiction. The terms are defined at 42 CFR 34.2(h) and (i).

Include here any diagnosis of drug abuse or drug addiction.

"Drug abuse" is "current substance use disorder or substance-induced disorder, mild," **but only** with respect to substances listed in Schedule I, II, III, IV, or V of section 202 of the Controlled Substances Act. Make the diagnosis according to the diagnostic criteria in the most current edition of the DSM, or by another authoritative source as determined by the director of the CDC.

"Drug addiction" is "current substance use disorder or substance-induced disorder, moderate or severe," **but only** with respect to substances listed in Schedule I, II, III, IV, or V of section 202 of the Controlled Substances Act. Make the diagnosis according to the diagnostic criteria in the most current edition of the DSM.

You may also make a diagnosis of full remission, according to the diagnostic criteria in the most current edition of the DSM or another authoritative source as determined by the director of the CDC. See the CDC's Technical Instructions for more information.

A. Findings:

- **(1)** ☐ No Class A or B Substance (Drug) Abuse/Addiction
- **(2)** ☐ Substance (Drug) **Abuse**, Listed in section 202 of the Controlled Substances Act, Class A
- **(3)** ☐ Substance (Drug) **Addiction**, Listed in section 202 of the Controlled Substances Act, Class A
- **(4)** ☐ Substance (Drug) **Abuse** in Full Remission, Listed in section 202 of the Controlled Substances Act, Class B
- **(5)** ☐ Substance (Drug) **Addiction** in Full Remission, Listed in section 202 of the Controlled Substances Act, Class B

B. Remarks: (Include any therapy given, rehabilitation, counseling or referrals. If you need extra space to complete this section, use the space provided in **Part 10. Additional Information**.

4. Other Medical Conditions (List any other Class B conditions, such as hypertension or diabetes.)

5. Required Referral to Health Department or Other Doctor (To be completed by civil surgeon, if a referral is medically required. Do not complete if a referral is not required, such as recommended referral for LTBI treatment.)

A. Type or Print Name of Doctor or Health Department Receiving Required Referral

Family Name (Last Name)	Given Name (First Name)	Middle Name	A-Number (if any)
			► A-

Part 7. Civil Surgeon Worksheet (continued)

B. Address

Street Number and Name | Apt. Ste. Flr. | Number

City or Town | State | ZIP Code

C. Date of Referral (mm/dd/yyyy)

D. Remarks: (Include the name of medical condition and the reasons for referral. **If you need extra space to complete this section, use the space provided in Part 10. Additional Information**.

Part 8. Referral Evaluation (To be completed by the health department or other doctor performing the referral evaluation)

The applicant identified on this Form I-693 was referred to me by the civil surgeon named in **Part 6.** of this Form I-693. I have provided appropriate evaluation/treatment, having made every reasonable effort to verify that the person whom I have evaluated/ treated is the person identified in **Part 1**.

1. Evaluating Physician or Health Department's Full Name

A. Family Name (Last Name) | Given Name (First Name) | Middle Name

B. Health Department 's Name

2. Address

Street Number and Name | Apt. Ste. Flr. | Number

City or Town | State | ZIP Code

3. Signature of Health Department Individual or Other Doctor Performing Referral Evaluation

Signature | Date Signed (mm/dd/yyyy)

4. Name of Medical Practice or Health Department

5. Daytime Telephone Number

NOTE: If you need extra space to complete this section, use the space provided in **Part 10. Additional Information**.

Family Name (Last Name)	Given Name (First Name)	Middle Name	A-Number (if any)
			▶ A-

Part 9. Vaccination Record

NOTE: See *Technical Instructions* at **www.cdc.gov/immigrantrefugeehealth/exams/ti/civil/vaccination-civil-technical-instructions.html** for list of required vaccines.

Please make sure to mark every row. Reserve all comments for the Remarks section below. **NOTE:** For purposes of the influenza vaccine, the flu season is October 1 through March 31. **For applicants who only require a vaccination assessment:** Submit only this page with **Part 1.**, **Part 2.**, **Part 3.**, **Part 4.**, and **Part 6.** of Form I-693. (If you need an interpreter, complete **Part 3. Interpreter's Contact Information, Certification, and Signature**.) For more information, see Form I-693 Instructions, **Frequently Asked Questions.**

Vaccine History Transferred From A Written Record					**Vaccine Given**	**Complete Series**	**Blanket Waivers to be Requested from USCIS (Not Medically Appropriate)**			
Vaccine	Date Received (mm/dd/yyyy)	Date Received (mm/dd/yyyy)	Date Received (mm/dd/yyyy)	Date Received (mm/dd/yyyy)	Date Given by Civil Surgeon (mm/dd/yyyy)	Mark an X if complete; write date of lab test if immune or "VH" if varicella history	Not Age - Appropriate	Contra-indication	Insufficient Time Interval	Not Flu Season
Specify Vaccine: DT ☐ DTaP ☐ DTP ☐							☐	☐	☐	
Specify Vaccine: Td ☐ Tdap ☐							☐	☐	☐	
Specify Vaccine: OPV ☐ IPV ☐							☐	☐	☐	
MMR (measles, mumps-rubella) or if monovalent or other combination of the vaccines are given, specify vaccines							☐	☐	☐	
Hib							☐	☐	☐	
Hepatitis B							☐	☐	☐	
Varicella							☐	☐	☐	
Pneumococcal							☐	☐	☐	
Influenza							☐	☐	☐	☐
Rotavirus							☐	☐	☐	
Hepatitis A							☐	☐	☐	
Meningococcal							☐	☐	☐	

NOTE: Give a copy to the applicant.

Family Name (Last Name)	Given Name (First Name)	Middle Name	A-Number (if any)
			► **A-**

Part 9. Vaccination Record (continued)

Results:

- ☐ Applicant may be eligible for blanket waivers as indicated above
- ☐ Applicant will request an individual waiver based on religious or moral convictions
- ☐ Vaccine history complete for each vaccine, all requirements met
- ☐ Applicant does not meet immunization requirements

Remarks: (If needed, provide any comments, such as the reason for contraindication.)

FOR USCIS USE ONLY

Remarks (if any)

Part 10. Additional Information

If you (the applicant or the civil surgeon) need extra space to provide any additional information within this form use the space below. If you (the applicant or civil surgeon) need more space than what is provided, you may make copies of this page to complete and file with this form or attach a separate sheet of paper. Type or print the applicant's name and A-Number (if any) at the top of each sheet; indicate the **Page Number**, **Part Number**, and **Item Number** to which your answer refers; and sign and date each sheet.

1. Family Name (Last Name) | Given Name (First Name) | Middle Name

2. A-Number (if any) ► **A-**

3. **A.** Page Number **B.** Part Number **C.** Item Number

D.

4. **A.** Page Number **B.** Part Number **C.** Item Number

D.

5. **A.** Page Number **B.** Part Number **C.** Item Number

D.

6. **A.** Page Number **B.** Part Number **C.** Item Number

D.