

START HERE - Type or print in black ink.

Part 1. Inform	nation About	You (To be con	npleted by the p	person requestin	ng a medical	examination,	NOT the
civil surgeon.)							

1.	Your Full Legal Name (Do not provide a nickname)	
	Family Name (Last Name) Given Name (First	t Name) Middle Name (if applicable)
2.	Current Physical Address (USPS ZIP Code Lookup)	
	In Care Of Name (if any)	
	Street Number and Name	Apt. Ste. Flr. Number
	City or Town	State ZIP Code
	Province Postal Code	Country
3.	Other Information	
	A. Gender B. Date of Birth (mm/dd/yyyy) C.	City/Town/Village of Birth
	Male Female	
	D. Country of Birth E.	Alien Registration Number (A-Number) (if any)
		► A-
	F. USCIS Online Account Number (if any)	

4. Immigration Medical Examination Requirement

A. I am eligible for completion of the vaccination record portion only, because I previously completed an overseas immigration medical examination, signed by a panel physician (refugee or derivative asylee adjustment of status applicants under Immigration and Nationality Act (INA) section 209 and K nonimmigrant visa holders applying for adjustment of status).

NOTE: If you selected this box for Item A. in Item Number 4., you, the applicant, and the civil surgeon are responsible for completing Parts 1. - 5., Part 7., and Part 10.

Family Name (Last Name)	Given Name (First Name)	Middle Name	A-Number (if any)
			► A-
Part 2. Applicant's Statemen	t, Contact Information,	Certification, and	Signature
Applicant's Contact Information	on		
Provide your daytime telephone numb	per, mobile telephone number	(if any), and email addre	ess (if any).
1. Applicant's Daytime Telephone N	Jumber	2. Applicant's Mobil	e Telephone Number (if any)
3. Applicant's Email Address (if any	()		
Applicant's Certification and S	Signature		

I certify, under penalty of perjury, that I provided or authorized all of the responses and information contained in and submitted with my application, I read and understand or, if interpreted to me in a language in which I am fluent by the interpreter listed in **Part 3.**, understood, all of the responses and information contained in, and submitted with, my form, and that all of the responses and the information are complete, true, and correct. I understand the purpose of this immigration 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 immigration medical examination, I understand that any immigration benefit I derived from this immigration 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. Furthermore, I authorize the release of any information from any and all of my records that USCIS may need to determine my eligibility for an immigration request and to other entities and persons where necessary for the administration and enforcement of U.S. immigration law.

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

4. Applicant's Signature

Date of Signature (mm/dd/yyyy)

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

Interpreter's Full Name

Interpreter's Family Name (Last Name)

 Interpreter's Given Name (First Name)
 Interpreter's Business or Organization Name
 Interpreter's Contact Information

 Interpreter's Daytime Telephone Number

 Interpreter's Mobile Telephone Number (if any)
 Interpreter's Email Address (if any)

Family Name (Last Name)	Given Name (First Name)	Middle Name			A-Nu	imber	íf an	y)	
				А-					
Part 3. Interpreter's Contac	et Information, Certification	on, and Signature	e (con	tinue	d)				
Interpreter's Certification an	d Signature								
certify, under penalty of perjury, th	at I am fluent in English and					,	and I	have	
nterpreted every question on the app nd the applicant informed me that t		1 11			-		s in th	at lan	guage
Interpreter's Signature	ney understood every instruction,	question, and answer	on the		ate of S		ure (n	nm/dc	l/vvv
						0			
	n, Declaration, and Signatu	ire of the Person	Prepa	aring	g this	Арр	licati	on, i	if
Part 4. Contact Information Other Than the Applicant Preparer's Full Name						Арр	licati	on, i	if
Other Than the Applicant		Preparer's Given Na				Арр	licati	on, i	if
Other Than the Applicant Preparer's Full Name	lame)					App	licati	on, i	if
Other Than the Applicant Preparer's Full Name . Preparer's Family Name (Last N	lame) tion Name					Арр	licati	on , i	if
Other Than the Applicant Preparer's Full Name • Preparer's Family Name (Last N • Preparer's Business or Organiza • Preparer's Contact Information	Iame) tion Name		ame (F	irst Na	ame)			on, i	
Other Than the Applicant Preparer's Full Name • Preparer's Family Name (Last N • Preparer's Business or Organiza • Preparer's Contact Information	Iame) tion Name tion Name Under	Preparer's Given Na	ame (F	irst Na	ame)			on, i	f

I certify, under penalty of perjury, that I prepared this application for the applicant at their request and with express consent and that all of the responses and information contained in and submitted with the application are complete, true, and correct and reflects only information provided by the applicant. The applicant reviewed the responses and information and informed me that they understand the responses and information in or submitted with the application.

6. Preparer's Signature

Date of Signature (mm/dd/yyyy)

Parts 5. - 10. of this form must be completed by the civil surgeon.

Part 5. 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-	
Do	art 6. Summary of Medical	Examination (To be co	mplated by the civil su	irgeon)	
1.	Summary of Overall Findings:	Examination (10 de co	inpleted by the civil st		
1.	A. No Class A or Class B Con	ndition			
		Item Numbers 1 4. in Par	t 8. Civil Surgeon Works	heet)	
		Item Numbers 1 3. in Par	0	,	
2.	Date of First Examination (Date a (mm/dd/yyyy)	pplicant signed in Part 2.)			
3.	Dates of Follow-up Examinations,	, if required:			
	Date of Examination (mm/dd/yyy	y) Date of Examination (mm/dd/yyyy) Date of I	Examination (mm/dd/yyyy)
Pa	art 7. Civil Surgeon's Conta	ct Information, Certifi	cation, and Signature	e	
NO	TE: Do not sign Form I-693 until	all health-related follow-up 1	requirements are met.		
Ci	vil Surgeon's Information				
1.	Family Name (Last Name)	Given I	Name (First Name)	Middle	Name (if applicable)
	Civil Surgeon Identification Number	per (CSID) (unless performin	g the examination under a		
	health department or military blan	ket designation)			
2.	Name of Medical Practice, Facility	y, or Health Department			
Ph	ysical Address				
3.	Street Number and Name			Apt. Ste. Flr.	Number
	City or Town			State	ZIP Code
M	ailing Address				
4.	Street Number and Name (PO Box)		Apt. Ste. Flr.	Number (if applicable)
	City or Town			State	ZIP Code
Ca	ontact Information				
5.	Daytime Telephone Number		6. Mobile Telephone	Number (if an	y)
7.	Email Address (if any)				

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

Α

Part 7. 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 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 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 for Civil Surgeons*, 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 8. Civil Surgeon Work			
(To be completed by the civil surge https://www.cdc.gov/immigrantr	•	· ·	ons at
1. Communicable Disease of Pub	C		
	under 2 years of age, see the Tech), is required for all applicants 2 years of <i>Surgeons</i> . The civil surgeon will
(1) Interferon Gamma Re updates posted on the		As, consult the <i>Technical</i> A	Instructions for Civil Surgeons and any
Not Administered	d (IGRA exception; please expla	in in Remarks section belo	w)
Select only one b	DOX.		
QuantiFERC	DN	T-Spot	
Date Blood S	Sample Drawn (mm/dd/yyyy)	Date Blood Sam	ple Drawn (mm/dd/yyyy)
Result:	Negative (no chest X-ray requir	ed)	
	Positive (chest X-ray required)		
	Indeterminate (including border	line/equivocal) (no chest X	K-ray required)
(2) Initial Screening Test	Result and Chest X-Ray Determ	inations:	
	equired (medically cleared for T		
	ired due to initial screening test n		
	ired due to TB signs or symptom		
	• ·	arly specify the IGRA exc	eption in the Remarks section below.).
Sputum Smears and Culture			
• • • •	ed based on IGRA result, or if sp mosuppression (such as HIV).	pecific IGRA exceptions ap	oply, or for an applicant with TB signs
Date Chest X-Ray Ta	ken (mm/dd/yyyy) D	ate Chest X-Ray Read (mi	n/dd/yyyy)
Result: Norma	1		
Abnor	mal findings suggestive of TB th	at require smears and cultu	ires:
	filtrate or consolidation	Miliary find	lings
	eticular markings suggestive of f	ibrosis Discrete lin	ear opacity
	avitary lesion		dule(s) without calcification
	odule(s) or mass with poorly defi argins (such as tuberculoma)	ined 🗌 Volume los	s or retraction
🗌 Pl	eural effusion	Irregular th	ick pleural reaction
H	ilar/mediastinal adenopathy	Other (furth	her describe in Remarks section below)

Part 8. Civil Surgeon Worksheet (continued)

- (4) Sputum Smears and Cultures Decision
 - No, not indicated.
 - Yes, indicated due to signs or symptoms of TB.
 - Yes, indicated due to chest X-ray suggestive of TB.
- Yes, indicated for end of treatment cultures.

extrapulmonary TB.

Yes, indicated due to known HIV infection or

► A-

(5) Sputum Smears and Cultures Results

		Sputum Smear Results		
	Date Specimen Obtained (mm/dd/yyyy)	Date Smear Result Reported (mm/dd/yyyy)	Positive	Negative
1.				
2.				
3.				
		•	•	

		Sputum Culture Re	sults			
	Date Specimen Obtained (mm/dd/yyyy)	Date Culture Result Reported (mm/dd/yyyy)	Positive	Negative	NTM	Contaminated
1.						
2.						
3.						

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

No Class A or Class B TB Class B1 Extrapulmonary TB

Class B2 TB, Latent TB Infection

Class A Pulmonary TB Disease

Class B, Other Chest Condition (non-TB)

Class B1 Pulmonary TB

Class B0 Pulmonary TB

(7) 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 IGRA, give the reason why an exception applies.)

B. Syphilis

(1) Serologic Test for Syphilis (Required for applicants 18 to 44 years of age - see CDC's Syphilis Technical Instructions for Civil Surgeons at https://www.cdc.gov/immigrantrefugeehealth/civil-surgeons/syphilis.html for current required testing age range). All tests must be performed on the same blood sample.

(a) Name of Nontreponemal Test	
(b) Date Nontreponemal Test Collected (mm/dd/yyyy)	

(c) Nontreponemal Test Nonreactive Date Reported (mm/dd/yyyy)

Screening Reactive, Titer 1:

Family	V Name (Last Name)	Given Name (First Name)	Middle Name		A-Number (if any)
				► A-	
Part 8. C	ivil Surgeon Works	heet (continued)			
	(d) Name of Treponema	ıl Test			
	(e) Date Treponemal Te	est Reported (mm/dd/yyyy)			
	(f) Terponemal Tes	t Nonreactive 🗌 Treponen	al Test Reactive		
		orithm and treponemal test re- referably one based on differ		test nonr	eactive: Name of Repeat
	(h) Date Repeat Trepon	emal Test Reported (mm/dd	/уууу)		
	(i) Repeat Trepone	mal Test Nonreactive	Repeat Treponemal Test	Reactive	
(2)	Findings:				
	No Class A or Class	B Syphilis Syphilis,	Class A (untreated)] Syphilis	s, Class B (treated in the last year)
(3)	· · ·	of syphilis diagnosed [prim yphilis, congential] and any			
		, phillis, congentiar, and any	anorapy given with doses t	and dutes	
	Drug:		Dosage:		
	Start Date (mm/dd/yyyy)		End Date (mm/c	ld/yyyy)	
C. Goi	norrhea				
(1)		orrhea (Required for applica			
	Instructions for Civil Sur current required testing a		ov/immigrantrefugeehea	lth/civil-	<mark>surgeons/gonorrhea.html</mark> for
	(a) Screening Nucleic A	cid Amplification Test (NA	AT) Name		
	(b) Date Result Reporte	d (mm/dd/yyyy)			
		Negative			
(2)	Findings:	C			
	No Class A or Class	B Gonorrhea 🗌 Gonorrh	ea, Class A (untreated)		
	Gonorrhea, Class B ((treated in the last year)			
(3)	Remarks: (Include any s	symptoms or treatment given	with doses and dates of a	dministra	tion.)
	Drug:		Dosage:		
	Start Date (mm/dd/yyyy)		End Date (mm/d	ld/yyyy)	

Part 8. Civil Surgeon Worksheet (continued)

- D. Other Class A/Class B Conditions for Communicable Diseases of Public Health Significance. For instructions, see the CDC's *Technical Instructions for Civil Surgeons* for Hansen's Disease at https://www.cdc.gov/immigrantrefugeehealth/civil-surgeons/hansens-disease-leprosy.html.
 - (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: (If you need extra space to complete this section, use the space provided in **Part 11. Additional Information**. Include any therapy given and any counseling or referrals.)
- 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-use 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-use 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 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 Civil Surgeons* for Other Physical or Mental Abnormality, Disease or Disability at <u>https://www.cdc.gov/immigrantrefugeehealth/civil-surgeons/other-abnormality-disease-or-disability.html</u> for more information.

- **A.** Findings:
 - (1) No Class A or B Physical or Mental Disorder
 - (2) Physical/Mental Disorder with Associated Harmful Behavior, Class A
 - (3) Physical/Mental Disorder with a History of Associated Harmful Behavior Likely to Recur, Class A
 - (4) Physical/Mental Disorder without Associated Harmful Behavior, Class B
 - (5) Physical/Mental Disorder with a History of Associated Harmful Behavior Unlikely to Recur, Class B
- **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 11. Additional Information**.)

Part 8. Civil Surgeon Worksheet (continued)

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 or drug addiction" is "current substance use disorder mild, 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, or by another authoritative source as determined by the director of the CDC.

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 Civil Surgeons* for Mental Health at <u>https://www.cdc.gov/immigrantrefugeehealth/civil-surgeons/mental-health.html</u> for more information.

A. Findings:

- (1) No Class A or B Substance (Drug) Abuse/Addiction
- (2) Substance (Drug) Abuse or Addiction, listed in section 202 of the Controlled Substances Act, Class A
- (3) Substance (Drug) Abuse in Full Remission, listed in section 202 of the Controlled Substances Act, Class B
- (4) Substance (Drug) Addiction in Full Remission, listed in section 202 of the Controlled Substances Act, Class B
- **B.** 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 11. Additional Information**.)

4. Other Medical Conditions (List any other Class B conditions, such as hypertension or diabetes, and all required evaluation components as found in CDC's *Technical Instructions for Civil Surgeons* at https://www.cdc.gov/immigrantrefugeehealth/civil-surgeons/medical-history-and-physical-exam.html.)

Family Name (Last Name)	Given Name (First Name)	Middle Name	A-	Number (if any)
			► A-	
t 8. Civil Surgeon Work	sheet (continued)			
Required Referral to Health Dep	artment or Other Doctor (To be c	completed by civil surgeon	n, if a referral i	s medically required.)
-			n, if a referral i	s medically required.)
			n, if a referral i	s medically required.)
			n, if a referral i	s medically required.)
A. Type or Print Name of Doct			n, if a referral i	s medically required.)
A. Type or Print Name of Doct		ving Required Referral	n, if a referral i Apt. Ste. Flr.	
		ving Required Referral		
A. Type or Print Name of DoctB. Address		ving Required Referral		

- 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 11. Additional Information**.)

Part 9. 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 7.** 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 (if applicable)
B.	Health Department 's Name		

2. Address

	Street Number and Name	Ap	t. Ste. Flr.	Number		
	City or Town	Sta	ite	ZIP Code		
3.	Signature of Health Department Individual or Other Doctor Performing Referral Evaluat	ion	1			
	Signature		Date Signe	d (mm/dd/yyyy)		
4.	Name of Medical Practice or Health Department	5.	Daytime Te	elephone Number		

Part 10. Vaccination Record

NOTE: See *Technical Instructions for Civil Surgeons* at <u>www.cdc.gov/immigrantrefugeehealth/exams/ti/civil/vaccination-civil-technical-instructions.html</u> for a list of required vaccines, and <u>https://www.cdc.gov/immigrantrefugeehealth/civil-surgeons/</u> <u>covid-19-technical-instructions.html</u> for COVID-19 specific vaccine guidance.

Please make sure to mark every row. Reserve all comments for the Remarks section below. For applicants who only require a vaccination assessment: Submit only this Part with Parts 1. - 5., and Part 7. 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 Waiver(s) 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 "X" if complete; write date of lab test if immune or "VH" if varicella history	Not Age -	Contra- indication	Insufficient Time Interval	*See Below Table
Specify Vaccine:										
Specify Vaccine:										
Specify Vaccine:										
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										
COVID-19 (In "Remarks" section, write "COVID-19" and specify vaccine brand)										

NOTE: Give a copy to the applicant.

► A-

Part 10. Vaccination Record (continued)

***For influenza vaccine**, check the box in this column only if vaccine is not available in the location where the civil surgeon practices. The civil surgeon is responsible for knowing local availability of the influenza vaccine.

***For COVID-19 vaccine**, check the box in this column only if vaccine is not routinely available in the location where the civil surgeon practices according to the *Technical Instructions for Civil Surgeons* blanket waivers for this vaccine.

Results:	FOR USCIS USE ONLY
Applicant completed vaccination requirements or may be eligible for blanket waivers as indicated above.	Remarks (if any)
Applicant will request an individual waiver based on religious or moral convictions.	
Applicant does not meet immunization requirements.	
Remarks: (If needed, provide any comments, such as the reason for contraindication.)	

Part 11. 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 (if applicable)		
2.	A-Number (if any) ► A-				
3.	A. Page Number B. Part Number D.	C. Item Number			
	A Dece Marchan B Dec Marchan	C. Keen N. ed. or			
4.	A. Page Number B. Part Number D.	C. Item Number			
-	A Dave Number D Darf Number	C. Item Nember			
5.	A. Page Number B. Part Number D.	C. Item Number			
6.	A. Page Number B. Part Number D.	C. Item Number			