



Report of Immigration Medical Examination and Vaccination Record

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

USCIS
Form I-693
OMB No. 1615-0033
Expires 03/31/2025

▶ **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 Legal Name (Do not provide a nickname)

Family Name (Last Name)

Given Name (First 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

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)

▶

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- <input type="text"/>

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

Applicant's Contact Information

Provide your daytime telephone number, mobile telephone number (if any), and email address (if any).

- Applicant's Daytime Telephone Number
- Applicant's Mobile Telephone Number (if any)
- Applicant's Email Address (if any)

Applicant's Certification and 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.

- 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-Number (if any)			
			▶ A-			

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)

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(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 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 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 Civil Surgeons* for Other Physical or Mental Abnormality, Disease or Disability at <https://www.cdc.gov/immigrantrefugeehealth/civil-surgeons/other-abnormality-disease-or-disability.html> 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**.)

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

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 <https://www.cdc.gov/immigrantrefugeehealth/civil-surgeons/mental-health.html> 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- <input type="text"/>

Part 8. Civil Surgeon Worksheet (continued)

5. Required Referral to Health Department or Other Doctor (To be completed by civil surgeon, if a referral is medically required.)

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

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 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

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 11. Additional Information.**

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

Part 10. Vaccination Record

NOTE: See *Technical Instructions for Civil Surgeons* at www.cdc.gov/immigrantrefugeehealth/exams/ti/civil/vaccination-civil-technical-instructions.html for a list of required vaccines, and <https://www.cdc.gov/immigrantrefugeehealth/civil-surgeons/covid-19-technical-instructions.html> 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 - Appropriate	Contra-indication	Insufficient Time Interval	*See Below Table
Specify Vaccine: <input type="checkbox"/> DT <input type="checkbox"/> DTaP <input type="checkbox"/> DTP							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Specify Vaccine: <input type="checkbox"/> Td <input type="checkbox"/> Tdap							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Specify Vaccine: <input type="checkbox"/> OPV <input type="checkbox"/> IPV							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
MMR (measles, mumps, rubella) or, if monovalent or other combination of the vaccines are given, specify vaccines							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hib							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis B							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Varicella							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pneumococcal							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Influenza							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rotavirus							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis A							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Meningococcal							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
COVID-19 (In "Remarks" section, write "COVID-19" and specify vaccine brand)							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NOTE: Give a copy to the applicant.

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

- Applicant completed vaccination requirements or may be eligible for blanket waivers as indicated above.
- 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.)

FOR USCIS USE ONLY
Remarks (if any)

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 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.
