

I-905, Application for Authorization to Issue Certification for Health Care Workers

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

START HERE - Please type or print in black ink.

For USCIS Use Only

Part 1. Information about the applicant filing this form.

Company or Organization

Address

Street Number and Name

Room #

City

State

Zip/Postal Code

IRS Tax #

Name of Point of Contact

Phone # of Point of Contact
()

Title of Point of Contact

Date organization was created.

Description of your organization.

Occupations for which you are seeking authorization.

Describe the process you will use to issue certificates *(If more space is required, use a separate sheet(s) of paper).*

Explain your organization's expertise, knowledge and experience in the health care occupations for which you are seeking authorization.

Returned 	Receipt
Resubmitted 	
Reloc Sent 	
Reloc Rec'd 	

- Approved for all requested occupations.
- Partial approval (USCIS must list approved occupations.)

Action Block

**To Be Completed by
Attorney or Representative, if any**

Fill in box if G-28 is attached to represent the petitioner

VOLAG#

ATTY State License #

Explain how your organization meets the standards described in the instructions sheet. *(If more space is required, attach a separate sheet(s) of paper).*

Describe the procedure you will establish for U.S. Citizenship and Immigration Services to use to verify the validity of your certificates.

Part 2. Signature. *Read the information on penalties in the instructions before completing this section.*

I certify, under penalty of perjury under the laws of the United States of America, that this application and the evidence submitted with it are all true and correct. If filing this on behalf of an organization, I certify that I am empowered to do so by that organization. I authorize the release of any information from my records or from the applicant's organization's records that U.S. Citizenship and Immigration Services needs to determine eligibility for the benefit I am seeking. If this application is approved, I also agree to provide U.S. Citizenship and Immigration Services with any information that it requests to determine the organization's eligibility to continue to issue certificates to health care workers.

Signature and Title	Print Name	Date
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NOTE: *If you do not completely fill out this form or fail to submit required documents listed in the instructions, this application may be denied.*

Part 3. Signature of person preparing form, if other than above. (Sign below.)

I declare that I prepared this application at the request of the above person and it is based on all information of which I have knowledge.

Signature	Print Name	Date
Firm Name and Address (Street Number and Name; Suite/Room Number; City/Town; State; Zip Code)	Daytime Telephone Number (<i>Area Code and Number</i>) ()	Fax Number (<i>Area Code and Number</i>) ()
	E-Mail Address (<i>If any</i>)	