OMB No. 1615-0033; Expires 08/31/09

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

I-693, Report of Medical Examination and Vaccination Record

START HERE - Please type or print in CAPITAL letters (*Use black ink*)

Part 1. Information about you *(The person requesting a medical examination or vaccinations must complete this part)*

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

Home Address: Street Number and Name | Apt. Number | Gender: ☐ Male ☐ Female

City | State | Zip Code | Phone Number *(Include Area Code)*

Date of Birth *(mm/dd/yyyy)* | Place of Birth *(City/Town/Village)* | Country of Birth | A-number *(if any)* | U.S. Social Security # *(if any)*

Applicant's Certification

I certify under penalty of perjury under United States law that I am the person who is identified in **Part 1** of this Form I-693, Report of Medical Examination and Vaccination Record, and that the information in **Part 1** of this form is true to the best of my knowledge. I understand the purpose of this medical exam, 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/altered information or documents with regard to my medical exam, I understand that any immigration benefit I derived from this medical exam may be revoked, that I may be removed from the United States, and that I may be subject to civil or criminal penalties.

Signature - Do not sign or date this form until instructed to do so by the civil surgeon | **Date** *(mm/dd/yyyy)*

Part 2. Medical examination *(The civil surgeon completes this part)*

1. Examination

Date of First Examination

Date(s) of Follow-up Examination(s) if Required:
Date of Exam | Date of Exam | Date of Exam

Summary of Overall Findings:
☐ No Class A or Class B Condition ☐ Class A Conditions (see **2** through **5** below) ☐ Class B Conditions (see **2** through **6** below)

2. Communicable Diseases of Public Health Significance

A. Tuberculosis (TB)

☐ Tuberculin Skin Test (TST) (Required for applicants 2 years of age and older: for children under 2 years of age, see pp. 11-12 of Technical Instructions at **http://www.cdc.gov/ncidod/dq/civil.htm.**)

Date TST Applied | Date TST Read | Size of Reaction *(mm)*

☐ Chest X-Ray - Required **ONLY** for TST reactions of ≥ 5mm or if specific TST exception criteria met, or for an applicant with TB symptoms or immunosuppression (e.g., HIV). **Attach copy of X-Ray Report**.

Date Chest X-Ray Taken | Date Chest X-Ray Read | Results ☐ Normal ☐ Abnormal (Describe results in remarks.)

Findings:
☐ No Class A or Class B TB ☐ Class B1 Pulmonary TB ☐ Class B2 Pulmonary TB ☐ Class B, Other Chest Condition (non-TB)
☐ Class A Pulmonary TB Disease ☐ Class B1 Extra Pulmonary TB ☐ Class B, Latent TB Infection

Remarks: (Include any signs or symptoms of TB, additional tests, and therapy given, with stop and start dates and any changes.)

Part 2. Medical Examination *(Continued)*

B. Syphilis

☐ Serologic Test for Syphilis (Required for applicants 15 years and older)

Date Screening Run

If Reactive, Date Confirmation Run

☐ Screening Nonreactive
☐ Screening Reactive, Titer 1:
☐ Confirmation Nonreactive
☐ Confirmation Reactive

Findings:

☐ No Class A or Class B Syphilis
☐ Syphilis, Class A (untreated)
☐ Syphilis, Class B (with residual deficit, treated in the past year)

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

C. HIV/AIDS

☐ Serologic Test for HIV Antibody (Required for applicants 15 years and older)

Date Screening Run

☐ Screening Negative
☐ Screening Positive
☐ Screening Indeterminate

If Positive or Indeterminate, Date Confirmation Run

☐ Confirmation Negative
☐ Confirmation Positive

Findings:

☐ No Class A HIV
☐ HIV, Class A

Remarks: (Include any signs or symptoms of HIV infection, therapy given, and any counseling, or referrals.)

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

Findings:

☐ Chancroid, Class A
☐ Gonorrhea, Class A
☐ Hansen's Disease (Leprosy, Infectious), Class A
☐ Granuloma Inguinale, Class A
☐ Lymphogranuloma Venereum, Class A
☐ Hansen's Disease (Leprosy, Noninfectious), Class B

Remarks: (Include any therapy given and any counseling, or referrals.)

3. Physical or Mental Disorders With Associated Harmful Behavior

☐ Physical/Mental Disorder, With Associated Harmful Behavior, Class A
☐ Physical/Mental Disorder, Without Associated Harmful Behavior, Class B

Remarks: (Include diagnosis, with likelihood of harmful behavior to recur, therapy given, and any counseling, or referrals.)

4. Drug Abuse/Drug Addiction

☐ Substance (Drug) Use, Listed in Section 202 of Controlled Substance Act, Class A
☐ Substance (Drug) Use, Not Listed in Section 202 of Controlled Substance Act, But With Associated Harmful Behavior, Class A
☐ Prior Substance (Drug) Use in Remission, Class B

Remarks: (Include any therapy given, rehabilitation, counseling, or referrals.)

Part 2. Medical examination *(Continued)*

5. Vaccinations (See Technical Instructions at **http://www.cdc.gov/ncidod/dq/civil.htm** for list of required vaccines.)

Vaccine History Transferred From a Written Record				Vaccine Given	Completed Series	Waiver(s) to Be Requested From USCIS			
						Blanket			
						Not Medically Appropriate			
Vaccine	**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 completed; 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 ☐ DTP ☐ DTaP ☐									
Specify Vaccine: Td ☐ Tdap ☐									
Specify Vaccine: OPV ☐ IPV ☐									
MMR (Measles Mumps-Rubella) or if monovalent or other combination of the vaccines are given, specify vaccine(s):									
Hib									
Hepatitis B									
Varicella									
Pneumococcal									
Influenza									
Other Vaccine (specify below):									
Other Vaccine (specify below):									
Other Vaccine (specify below):									
Other Vaccine (specify below):									
Other Vaccine (specify below):									

Give Copy to Applicant

Results:
- ☐ Applicant may be eligible for blanket waiver(s) 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.

A-number *(if any)*

Name (*Type or print your name)*

Part 2. Medical examination *(Continued)*

6. List other medical conditions, Class B other (e.g. hypertension, diabetes)

Part 3. Referral to health department or other doctor/facility *(To be completed by Civil Surgeon, if referral was made)*

Type or Print Name of Doctor or Health Department

Date of Referral *(mm/dd/yyyy)*

Address: (Street Number and Name, City, State and Zip Code)

Daytime Phone Number *(Include Area Code)*

( )

Remarks: (Include name of medical condition and reasons for referral.)

Part 4. To Be Completed by Physician or Health Department Performing Referral Evaluation

The applicant identified on this form was referred to me by the civil surgeon named in **Part 5** of this form. I have provided appropriate evaluation/treatment.

Type or Print Full Name of Evaluating Physician or Health Department

Signature

Address: (Street Number and Name, City, State and Zip Code)

Date *(mm/dd/yyyy)*

Name of Medical Practice or Health Department

Daytime Phone Number *(Include Area Code)*

( )

Remarks: (Attach a separate sheet of paper, if needed.)

Part 5. Civil Surgeon's Certification *(Do not sign form or have the applicant sign in Part 1 until all health follow-up requirements have been met.)*

I certify under penalty of perjury under United States law that: I am a civil surgeon in current status designated to examine applicants seeking certain immigration benefits in the United States; I have a currently valid and unrestricted license to practice medicine in the state where I am performing medical examinations; I performed this examination of the person identified in **Part 1** of this Form I-693, after having made every reasonable effort to verify that person whom I examined is the person identified in **Part 1**; that I performed the examination in accordance with the Centers for Disease Control and Prevention's *Technical Instructions*, and all supplemental information or updates provided to me; and that all information provided by me on this form is true and correct to the best of my information, knowledge, and belief.

Type or Print Full Name *(First, Middle, Last)*

Signature

Address (Street Number and Name, City, State and Zip Code)

Date *(mm/dd/yyyy)*

Name of Medical Practice or Health Department

Daytime Phone Number *(Include Area Code)*

( )

Civil Surgeon ID #

E-Mail Address

Part 6. Health department identifying information. *(If completed by State or local health department on behalf of a refugee, place a stamp or seal where indicated.)*

Type or Print Name

(Place State or local health department stamp/seal below.)

Signature

Date *(mm/dd/yyyy)*

Daytime Phone Number *(Include Area Code)*