OMB No. 1615-0029; Expires 02/28/09

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

I-601, Application for Waiver of Grounds of Inadmissibility

Do not write in this block. For Government use only.

☐ 212 (a) (1) ☐ 212 (a) (6)
☐ 212 (a) (2) ☐ 212 (a) (9)
☐ 212 (a) (3)

Fee Stamp

TPS Applicant: ______________________ (specify ground(s))

A. Information about applicant

1. Family Name (Surname In CAPS) (First) (Middle)

2. Address (Number and Street) (Apartment Number)

3. (Town or City) (State/Country) (Zip/Postal Code)

Telephone Number E-Mail Address

4. Date of Birth *(mm/dd/yyyy)*

5. USCIS File Number
A-

6. City/Province-State of Birth

7a. Country of Birth

7b. Country of Citizenship/Nationality

8. Date of Visa Application

9. Visa Applied for at:

10. Reason for Inadmissibility: (Please include a statement explaining the acts, convictions, and medical conditions that make you inadmissible. If you seek a waiver of inadmissibility because you have a Class A Tuberculosis condition (as per HHS regulations), you must complete page 3 of this form. If you seek a waiver because you have a HIV infection, you must complete page 4 of this form. Applicants with physical or mental disorders must attach the information requested in the instructions.)

11. Applicant was previously in the United States, as follows:

City and State	From (Date)	To (Date)	Immigration Status

12. Applicant's U.S. Social Security Number (if any)

B. Information about relative, through whom applicant claims eligibility for a waiver

1. Family Name (Surname in CAPS) (First) (Middle)

2. Address (Number and Street) (Apartment Number)

3. (Town or City) (State) (Zip/Postal Code)

Telephone Number E-Mail Address

4. Relationship to Applicant

5. Immigration Status

FOR USCIS USE ONLY. DO NOT WRITE IN THIS AREA.

Initial receipt	Resubmitted	Relocated		Completed		
		Received	Sent	Approved	Denied	Returned

C. Information about applicant's other relatives in the United States *(List only U.S. citizens and permanent residents)*

1. Family Name (Surname in CAPS) (First) (Middle)

2. Address (Number and Street) (Apartment Number)

3. (Town or City) (State) (Zip/Postal Code)

4. Relationship to Applicant **5**. Immigration Status

1. Family Name (Surname in CAPS) (First) (Middle)

2. Address (Number and Street) (Apartment Number)

3. (Town or City) (State) (Zip/Postal Code)

4. Relationship to Applicant **5**. Immigration Status

1. Family Name (Surname in CAPS) (First) (Middle)

2. Address (Number and Street) (Apartment Number)

3. (Town or City) (State) (Zip/Postal Code)

4. Relationship to Applicant **5**. Immigration Status

Applicant's Signature and Certification.

I certify under penalty of perjury under the laws of the United States that this application and the evidence submitted with it are all true and correct to the best of my knowledge and abilities. I authorize the release of any information from my records that the U.S. Citizenship and Immigration Services (USCIS) needs to determine my eligibility for this waiver.

Signature of Applicant or Qualified Relative / Legal Guardian Date

Preparer's Signature and Certification.

I declare that this document was prepared by me at the request of the applicant or qualified relative/legal guardian of the applicant, and it is based on all information of which I have knowledge and/or was provided to me by the above named person in response to the exact questions contained on this form. I have not knowingly withheld any information.

Preparer's Signature Date

Preparer's Address Date

To Be Completed for Applicants With Class A Tuberculosis Condition (As Per HHS Regulations).

A. Statement by Applicant

Upon admission to the United States I will:

1. Go directly to the physician or health facility named in **Section B**;
2. Present all X-rays used in the visa medical examination to substantiate diagnosis;
3. Submit to such examinations, treatment, isolation, and medical regimen as may be required; and
4. Remain under the prescribed treatment or observation, whether on inpatient or outpatient basis, until discharged.

Signature of Applicant

Date

B. Statement by Physician or Health Facility

(May be executed by a private physician, health department or other public or private health facility, or military hospital.)

I agree to supply any treatment or observation necessary for the proper management of the alien's tuberculosis condition.

I agree to submit Form CDC 75.18, "Report on Alien with Tuberculosis Waiver," to the health officer named in **Section D**:

1. Within 30 days of the alien's reporting for care, indicating presumptive diagnosis, test results, and plans for future care of the alien; or
2. 30 days after receiving Form CDC 75.18, if the alien has not reported.

Satisfactory financial arrangements have been made. (This statement does not relieve the alien from submitting evidence, as required by consul, to establish that the alien is not likely to become a public charge.)

I represent (enter an "X" in the appropriate box and give the complete name and address of the facility below.)

1. Local Health Department
2. Other Public or Private Facility
3. Private Practice
4. Military Hospital

Name of Facility (Please type or print in black ink)

Address (Number and Street) **(Room/Suite Number)**

City, State and Zip Code

Signature of Physician **Date**

C. Applicant's Sponsor in the United States

Arrange for medical care of the applicant and have the physician complete **Section B**.

If medical care will be provided by a physician who checked **Box 2** or **3**, in **Section B**, have **Section D** completed by the local or State Health Officer who has jurisdiction in the United States area where the applicant plans to reside.

If medical care will be provided by a physician who checked **Box 4**, in **Section B**, forward this form directly to the military facility at the address provided in **Section B**.

Address in the United States where the alien plans to reside:

Address (Number and Street) (Apt #)

City, State and Zip Code

D. Endorsement of Local or State Health Officer

Endorsement signifies recognition of the physician or facility for the purpose of providing care for tuberculosis. If the facility or physician who signed his or her name in **Section B** is not in your health jurisdiction and not familiar to you, you may want to contact the health officer responsible for the jurisdiction of the facility or physician prior to endorsing.

Endorsed by: **Signature of Health Officer**

Date

Enter below the name and address of the Local Health Department where the "Notice of Arrival of Alien with Tuberculosis Waiver" should be sent when the alien arrives in the United States.

Official Name of Department

Address (Number and Street) (Room/Suite Number)

City, State and Zip Code

NOTE: If further assistance is needed, contact the USCIS office with jurisdiction over the intended place of U.S. residence of the applicant.

If you are approved for a waiver and after admission to the United States you fail to comply with the terms, conditions, and controls that were imposed, you may be subject to removal under Immigration and Nationality Act (INA) section 237(a).

To Be Completed for Applicants With Human Immunodeficiency Virus (HIV) Infection

A. Statement About Applicant

Upon admission to the United States I will:

1. Go directly to the physician or health facility named in **Section B**;
2. Present copies of diagnostic tests used in the visa examination to substantiate diagnosis;
3. Submit to counseling and such examinations, treatment, and medical regimen as may be required; and
4. Remain under prescribed treatment or observation, whether on inpatient or outpatient basis, until discharged.

Signature of Applicant

Date

B. Statement by Physician or Health Facility

(May be executed by a private physician, health department, or other public or private facility, or military hospital.)

I agree to supply counseling and any treatment or observation necessary for the proper management of the alien's HIV infection condition.

I agree to submit a copy of my evaluation of the alien's condition to the health officer named in Section D and to the Division of Quarantine (E03), Centers for Disease Control and Prevention (CDC), Atlanta Georgia 30333:

1. Within 30 days of the alien's reporting for care, indicating plans for future care of the alien; or
2. A report that the alien has not reported within 30 days after receiving a notice from the Division of Quarantine, CDC.

Satisfactory financial arrangements have been made. (This statement does not relieve the alien from submitting evidence, as required by consul, to establish that the alien is not likely to become a public charge.)

I represent (enter an "x" in the appropriate box and give the complete name and address of the facility below:)

1. Local Health Department ☐
2. Other Public or Private Facility ☐
3. Private Practice ☐
4. Military Hospital ☐

Name of Physician or Facility (Please type or print)

Address (Number & Street)

City, State, & Zip Code

Signature of Physician

Date

C. Applicant's Sponsor in the United States

Arrange for medical care of the applicant and have the physician of facility complete **Section B**.

If medical care will be provided by a physician who checked box 2 or 3 in **Section B**, have **Section D** completed by the local or State Health Officer who has jurisdiction in the area where the applicant plans to reside in the United States.

If medical care will be provided by a physician who checked box 4 in **Section B**, forward this form directly to the military facility at the address provided in **Section B**.

Address where the alien plans to reside in the United States:

Address (Number & Street) **APT No.**

City, State, & Zip Code

D. Endorsement of Local or State Health Officer

Endorsement signifies recognition of the physician or facility for the purpose of providing care for HIV infection. If the facility or physician who signed in Section B is not in your health jurisdiction and is not familiar to you, you may wish to contact the health officer responsible for the jurisdiction of the facility or physician prior to endorsing.

Endorsed by: Signature of Health Officer

Date

Enter below the name and address of the Local Health Department to which the "Notice of Arrival of Alien with HIV infection Waiver" should be sent when the alien arrives in the United States.

Official Name of Department

Address (Number & Street) **APT No.**

City, State, & Zip Code

Please read instructions with care.

NOTE: If further assistance is needed, contact the USCIS office with jurisdiction over the intended place of U.S. residence of the applicant.

If you are approved for a waiver and after admission to the United States you fail to comply with the terms, conditions, and controls that were imposed, you may be subject to removal under Immigration and Nationality Act (INA) section 237(a).

OMB No. 1615-0029; Expires 02/28/09

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

I-601, Application for Waiver of Grounds of Inadmissibility

Do not write in this block. For Government use only.

☐ 212 (a) (1)
☐ 212 (a) (2)
☐ 212 (a) (3)
☐ 212 (a) (6)
☐ 212 (a) (9)

Fee Stamp

TPS Applicant: ______________________ (specify ground(s))

A. Information about applicant

1. Family Name (Surname In CAPS) (First) (Middle)
2. Address (Number and Street) (Apartment Number)
3. (Town or City) (State/Country) (Zip/Postal Code)

Telephone Number E-Mail Address

4. Date of Birth *(mm/dd/yyyy)*
5. USCIS File Number
A-
6. City/Province-State of Birth

7a. Country of Birth
7b. Country of Citizenship/Nationality

8. Date of Visa Application
9. Visa Applied for at:

10. Reason for Inadmissibility: (Please include a statement explaining the acts, convictions, and medical conditions that make you inadmissible. If you seek a waiver of inadmissibility because you have a Class A Tuberculosis condition (as per HHS regulations), you must complete page 3 of this form. If you seek a waiver because you have a HIV infection, you must complete page 4 of this form. Applicants with physical or mental disorders must attach the information requested in the instructions.)

11. Applicant was previously in the United States, as follows:

City and State	From (Date)	To (Date)	Immigration Status

12. Applicant's U.S. Social Security Number (if any)

B. Information about relative, through whom applicant claims eligibility for a waiver

1. Family Name (Surname in CAPS) (First) (Middle)
2. Address (Number and Street) (Apartment Number)
3. (Town or City) (State) (Zip/Postal Code)

Telephone Number E-Mail Address

4. Relationship to Applicant
5. Immigration Status

FOR USCIS USE ONLY. DO NOT WRITE IN THIS AREA.

Initial Receipt	Resubmitted	Relocated		Completed		
		Received	Sent	Approved	Denied	Returned

AGENCY COPY

C. Information about applicant's other relatives in the United States *(List only U.S. citizens and permanent residents)*

1. Family Name (Surname in CAPS)	(First)	(Middle)
2. Address (Number and Street)		(Apartment Number)
3. (Town or City)	(State)	(Zip/Postal Code)
4. Relationship to Applicant	**5**. Immigration Status	

1. Family Name (Surname in CAPS)	(First)	(Middle)
2. Address (Number and Street)		(Apartment Number)
3. (Town or City)	(State)	(Zip/Postal Code)
4. Relationship to Applicant	**5**. Immigration Status	

1. Family Name (Surname in CAPS)	(First)	(Middle)
2. Address (Number and Street)		(Apartment Number)
3. (Town or City)	(State)	(Zip/Postal Code)
4. Relationship to Applicant	**5**. Immigration Status	

USCIS Use Only: Additional Information and Instructions

Signature and Title of Requesting Officer

Address

Date