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 - 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 # *(Include Area Code) no dashes or ()*

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): An initial screening test, either a Tuberculin Skin Test (TST) or an Interferon Gamma Release Assay (IGRA) is required for all applicants 2 years of age and older; for children under 2 years of age, see *Technical Instructions* at **http://cdc.gov/ncidod/dq/civil.htm**. The civil surgeon should perform **one type of initial screening test only**, followed by further evaluation, if needed (chest X-ray).

1. Tuberculin Skin Test (TST):

☐ Not administered (TST exception applies)

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

Result: ☐ Negative (4mm or less of induration) ☐ Positive (≥ 5mm; chest X-ray required)

2. Interferon Gamma Release Assay (IGRA) (for acceptable IGRAs consult the Technical Instructions and any updates posted on CDC's Web site at http://www.cdc.gov/ncidod/dq/civil.htm):

☐ Not administered (IGRA exception applies) | Name of Test | Date Blood Sample Drawn

Part 2. Communicable Diseases of Public Health Significance *(Cont'd)*

IU/ml:

Result: ☐ Negative (including indeterminate, or borderline/ equivocal) (no chest X-ray required)

☐ Positive (chest X-ray required)

Initial Screening Test Result and Chest X-Ray Determination:

☐ Chest X-ray not required (medically cleared for TB for USCIS)

☐ Chest X-ray required due to initial screening test results

☐ Chest X-ray required due to TB signs or symptoms, or due to immunosuppression (e.g. HIV)

☐ Chest X-ray required due to TST or IGRA exception (The civil surgeon must clearly specify the TST or IGRA exception in the "Remarks" field below.)

4. Chest X-Ray: Required based on TST or IGRA result, or if specific TST or IGRA exceptions apply, or for an applicant with TB signs or symptoms or immunosuppression (e.g., HIV). Attach a copy of X-ray report.

Date Chest X-Ray Taken

Date Chest X-Ray Read

Results

☐ Normal

☐ Abnormal (Describe results in remarks.)

TB Classification/Findings (check only if chest x-ray was performed):

☐ No Class A or Class B TB

☐ Class A Pulmonary TB Disease

☐ Class B1 Pulmonary TB

☐ Class B1 Extra Pulmonary TB

☐ Class B2 Pulmonary TB

☐ Class B, Latent TB Infection

☐ Class B, Other Chest Condition (non-TB)

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, and 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:

☐ No Class A/B Condition
☐ Chancroid, Class A
☐ Granuloma Inguinale, Class A
☐ Gonorrhea, Class A
☐ Lymphogranuloma Venereum, Class A
☐ Hansen's Disease (Leprosy, Infectious), 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

☐ No Class A or B Physical or Mental Disorder
☐ 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

☐ No Class A or B Drug Abuse/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									
Rotavirus									
Hepatitis A									
Meningococcal									
Human Papillomavirus									
Zoster									

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 of Applicant

Remarks: *(If needed, provide any remarks; e.g., reason for contraindication)*

Part 2. Medical Examination *(Continued)*

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

Part 3. Referral to Health Department Other Doctor/Facility *(To be completed by civil surgeon, if referral was required and made)*

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

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

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

Daytime Phone # *(Include Area Code) no dashes or ( )*

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, having made every reasonable effort to verify that the person whom I evaluated/treated is the person identified in **Part 1**.

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 # *(Include Area Code) no dashes or ( )*

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; and that all information provided by me on this form is true and correct to the best of my 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 # *(Include Area Code) no dashes or ( )*

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 # *(Include Area Code) no dashes or ( )*

Part 7. For USCIS Use Only *(Not to be completed by the civil surgeon)*

☐ 212(g)(2)(B) Blanket Waiver for Vaccination Granted

Remarks (if needed):