TABLE OF CHANGES - FORM
Form I-693, Report of Medical Examination and Vaccination Record
OMB No. 1615-0033
12/09/2014

Reason for Revision: Making plain language edits; incorporating the blanket civil surgeon designation for military physicians into the form and instructions; and updating language to be consistent with the new Diagnostic and Statistical Manual of Mental Disorders (DSM-5)

Current Page Number and Section	**Current Text**	**Proposed Text**
Immediately following header	**START HERE - Type or print in CAPITAL letters (*Use black ink*)**	**START HERE - Type or print in black ink.**
Page 1, **Part 1. Information About You** (To be completed by the person requesting a medical examination, not the civil surgeon.)	Family Name (Last Name) Given Name (First Name) Full Middle Name Home Address: Street Number and Name Apt. Number City State Zip Code Gender: Male/Female Phone Number Date of Birth (mm/dd/yyyy) Place of Birth (City/Town/Village) Country of Birth A-Number (if any)	[Page 1] **Part 1. Information About You** (To be completed by the person requesting a medical examination, **NOT** the civil surgeon.) **1.** Family Name (Last Name) Given Name (First Name) Middle Name **2.** Street Number and Name Apt. Ste. Flr. Number City or Town State ZIP Code **3.** Gender Male Female **4.** Daytime Telephone Number **5.** Mobile Number (if any) **6.** Email Address (if any) **7.** Date of Birth (mm/dd/yyyy) **8.** City/Town/Village of Birth **9.** Country of Birth **10.** Alien Registration Number (A-Number) (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.	***Applicant's Certification*** I certify, under penalty of perjury, that I am the person who is identified in **Part 1.** of this Form I-693, and that the information in **Part 1.** of this benefit request is complete, true, and correct. I understand the purpose of this 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 medical examination, I understand that any immigration benefit I derived from this 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. Select the box for either **Item Number 11.** or **12.** **11.** I can read and understand English, and have read and understand every question and instruction in **Part 1.** of this Form I-693, as well as my answer to every question in **Part 1.** I have read and understand the above **Applicant's Certification**. **12.** The interpreter named in **Part 2.** has read to me every question and instruction in **Part 1.** of this Form I-693, as well as my answer to every question in **Part 1.**, in [Fillable Field], a language in which I am fluent. I understand every question and instruction in **Part 1.** of this Form I-693 as translated to me by my interpreter, and have provided complete, true, and correct responses in the language indicated above. The interpreter named in **Part 2.** also has read the above **Applicant's Certification** to me, in a language in which I am fluent, and I understand the **Applicant's Certification** as read to me by my interpreter

	Signature - Do not sign or date this form until instructed to do so by the civil surgeon **Date of Signature** *(mm/dd/yyyy)* To be completed by civil surgeon: Form of applicant ID presented (e.g., passport, driver's license) ID Number	***Applicant's Signature*** **13. Signature- Do not sign or date Form I-693 until instructed to do so by the civil surgeon.** **Date of Signature (mm/dd/yyyy)** **14. To be completed by the civil surgeon:** **A.** Form of applicant identification presented (for example, passport or driver's license) **B. Identification Number**
New		[Page 1] **Part 2. Interpreter's Contact Information, Certification, and Signature** **Provide the following information concerning the interpreter.** ***Interpreter's Full Name*** **1.** Interpreter's Family Name (Last Name) Interpreter's Given Name (First Name) **2.** Interpreter's Business or Organization Name (if any) ***Interpreter's Mailing Address*** **3.** Street Number and Name Apt./Ste./Flr. Number City or Town State ZIP Code Province Postal Code Country ***Interpreter's Contact Information*** **4.** Interpreter's Daytime Telephone Number **5.** Interpreter's Email Address (if any) ***Interpreter's Certification*** **I certify that:**

		I am fluent in English and [Fillable Field], which is the same language provided in **Part 1.**, **Item Number 12.**; I have read to this applicant every question and instruction in **Part 1.** of this Form I-693, as well as the answer to every question in **Part 1.**, in the language provided in **Part 1.**, **Item Number 12.**; and I have read the **Applicant's Certification** to the applicant in the same language provided in **Part 1.**, **Item Number 12.** The applicant has informed me that he or she undersands every instruction and question in **Part 1.** of this Form I-693, as well as the answer to every question in **Part 1.**, and the applicant verified the accuracy of every answer; and The applicant also has informed me that he or she understands the **Applicant's Certification**. ***Interpreter's Signature*** **6.** Interpreter's Signature Date of Signature (mm/dd/yyyy)
Page 1, **Part 2. Summary of Medical Examination** (*To be completed by the civil surgeon*)	Summary of Overall Findings: No Class A or Class B Condition Class A Conditions (see Civil Surgeon Worksheet, sections 1-3) Class B Conditions (see Civil Surgeon Worksheet, sections 1-4) Date of First Examination (mm/dd/yyyy)	**[Page 2]** **Part 3. Summary of Medical Examination** (To be completed by the civil surgeon) **1. Summary of Overall Findings:** A. __No Class A or Class B Condition B. __Class B conditions (See **Item Numbers 1. - 4.** in **Part 5. Civil Surgeon Worksheet** of this benefit request.) C. __Class A Conditions (See **Item Numbers 1. – 3.** in **Part 5. Civil Surgeon Worksheet** of this benefit request.)

	Date(s) of Follow-up Examination(s) below if required: Date of Exam (mm/dd/yyyy) Date of Exam (mm/dd/yyyy) Date of Exam (mm/dd/yyyy)	**2. Date of First Examination** (mm/dd/yyyy) **3. Dates of Follow up Examinations, if required:** **Date of Examination** (mm/dd/yyyy) **Date of Examination** (mm/dd/yyyy) **Date of Examination** (mm/dd/yyyy)
Page 1, **Part 3. 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 designated to examine applicants seeking certain immigration benefits in the U.S. OR a physician who qualifies under a blanket designation specified by	**[Page 2],** **Part 4. Civil Surgeon's Contact Information, Certification, and Signature** (Do not sign Form I-693 and do not have the applicant sign in **Part 1.** until all health-related follow-up requirements are met.) ***Civil Surgeon's Information*** 1.Family Name (Last Name) Given Name (First Name) Middle Name (if applicable) 2.Name of Medical Practice, Facility, or Health Department ***Physical Address*** 3.Street Number and Name Apt. Ste. Flr. Number City or Town State ZIP Code ***Contact Information*** 4. Daytime Telephone Number 5. Email Address (if any) ***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

	policy or law; I have a currently valid and unrestricted license to practice medicine in the state where I am performing medical examinations unless otherwise exempted; 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 the person whom I examined is in fact 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)* **Address** *(Street Number and Name, City, State, and Zip Code)* ***(Health Departments MUST place their official stamp or seal here)*** **Name of Medical Practice, Facility, or Health Department** **Signature** **Date Signed** *(mm/dd/yyyy)* **Daytime Phone Number** **E-Mail**	designation specified by policy or law; I have a currently valid and unrestricted license to practice medicine in the state where I am performing medical examinations, unless otherwise exempted; 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*, 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*** **6.Civil Surgeon's Signature** **Date of Signature (**mm/dd/yyyy**)** [See above] ***(Health departments and military treatment facilities MUST place their official stamp or seal here)*** [See above]
Pages 2-5,		[Page 3]

CIVIL SURGEON WORKSHEET *(To be completed by the civil surgeon, according to the* Technical Instructions *at http://www.cdc.gov/immigrantrefugeehealth/exams/ti/civil/technical-instructions-civil-surgeons.html)*		**Part 5. Civil Surgeon Worksheet** (To be completed by the civil surgeon, according to the *Technical Instructions* at **www.cdc.gov/immigrantrefugeehealth/exams/ti/civil/technical-instructions-civil-surgeons.html**)
	1. Communicable Diseases of Public Health Significance	**1. Communicable Disease 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*. The civil surgeon should perform **one type of initial screening test only**, followed by further evaluation, if needed (chest X-ray).	**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 the *Technical Instructions*. The civil surgeon should perform only **one type of initial screening test**, followed by further evaluation if needed (chest X-ray).
	1. Tuberculin Skin Test (TST):	**(1) Tuberculin Skin Test:**
	Not administered *(TST exception applies; please explain in Remarks section below)…*	Not administered (TST exception; please explain in Remarks section below)…
	2. Interferon Gamma Release Assay (IGRA) *(for acceptable IGRAs consult the* Technical Instructions *and any updates posted on CDC's Web site)*:	**(2) Interferon Gama Release Assay** (for acceptable IGRA's, consult the *Technical Instructions* and any updates posted on the CDC's Web site):
	Not administered *(IGRA exception applies; please explain in Remarks section below)*	__Not administered (IGRA exception; please explain in Remarks section below)
		Select **only one** box.
	Name of Test Date Blood Sample Drawn *(mm/dd/yyyy)* IU/ml:	__QuantiFERON Date Blood Sample Drawn (mm/dd/yyyy) __T-Spot Date Blood Sample Drawn (mm/dd/yyyy)
	Result: Negative (including indeterminate, or borderline/equivocal) *(no chest X-ray*	Result: __Negative (including indeterminate or borderline/equivocal) (no chest X-ray

	required) Positive *(chest X-ray required)* **3. 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 section 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). **Date Chest X-Ray Taken** *(mm/dd/yyyy)* **Date Chest X-Ray Read** *(mm/dd/yyyy)* Result: 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	required) __Positive (chest X-ray required) **(3) Initial Screening Test Result and Chest X-Ray Determinations:** 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 (such as HIV) Chest X-ray required due to TST or IGRA exception (Clearly specify the TST or IGRA exception in the Remarks section 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 (such as HIV). Date Chest X-Ray Taken (mm/dd/yyyy) Date Chest X-Ray Read (mm/dd/yyyy) Result: Normal Abnormal (describe results in Remarks section below.) TB Classification/Findings (Select 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:** *(If needed, include any signs or symptoms of TB, additional tests and therapy given, with start and stop dates and any changes. If tests were not administered, give reason why exception applies.)* **[Page 3]** **B. Syphilis** Serologic Test for Syphilis *(Required for applicants 15 years and older)…* Confirmation Reactive **Findings:** No Class A or Class B Syphilis Syphilis, Class A *(untreated)* Syphilis, Class B *(with or without residual deficit and treated in the past year)* **Remarks:** *(Include any therapy given with doses and dates)*	__Class B1 Extra Pulmonary TB __Class B2 Pulmonary TB __Class B, Other Chest Condition (non-TB) __Class B, Latent TB Infection (Answer the following question.) Was applicant referred for treatment (not required to complete Form I-693)? Yes/No **(5) Remarks: (**Include any signs or symptoms of TB, additional tests and therapy given, with start and stop dates and any changes. If you did not perform TST or IGRA, give the reason why an exception applies.) [Page 6] **B. Syphilis** **(1)** Serologic Test for Syphilis (Required for applicants 15 years of age and older)…. (a) Date Screening Run (mm/dd/yyyy) (b) Screening Nonreactive Screening Reactive, Titer 1: (c) If Reactive, Date Confirmation Run (mm/dd/yyyy) (d) Confirmation Nonreactive Confirmation Reactive, Titer 1:_ **(2) Findings** No Class A or Class B Syphilis Syphilis, Class A (untreated) Syphilis, Class B (treated in the last year) **(3) Remarks:** (Include any therapy given with doses and dates)

	C. Other Class A/Class B Conditions for Communicable Diseases of Public Health Significance…	**C. Other Class A/Class B Conditions for Communicable Diseases of Public Health Significance**
		(1) Findings…
	2. Physical or Mental Disorders With Associated Harmful Behavior	**2. Physical or Mental Disorders With Associated Harmful Behavior**
	* (Include here any diagnosis of substance abuse/addiction based on DSM criteria for a substance that is not listed in Schedule I, II, III, IV, or V under Section 202 of the Controlled Substance Act with current associated harmful behavior or history of associated harmful behavior judged likely to recur. This category includes diagnosis of alcohol abuse/dependence.)	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-related disorders based on Diagnostic and Statistical Manual (DSM) criteria for a 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-related disorder).
		A. Findings…
	Remarks: *(Include diagnosis, likelihood of recurrence of the harmful behavior, therapy given, and any counseling, or referrals. Attach a separate sheet of paper (with applicant's name and A-Number) if more space is necessary)*	**B. Remarks**: (Include diagnosis, likelihood of recurrence of the harmful behavior, therapy given, and any counseling or referrals. If you need more space, attach a separate sheet of paper; type or print the applicant's name and A-Number (if any), at the top of each sheet; and indicate the **Page Number**, **Part Number**, and **Item Number** to which your answer refers.)
		3. Drug Abuse/Drug Addiction
	3. Drug Abuse/Drug Addiction	"Drug Abuse/Drug Addiction" addresses non-medical use **only** with respect to substances listed in Schedule I, II, III, IV, or V of section 202 of the Controlled Substances Act. Include here any diagnosis of substance-related disorders based on DSM criteria for a substance listed in Schedule I, II, III, IV, or V of section 202 of the Controlled Substances Act. See the CDC's *Technical Instructions* for more
	** ("Drug Abuse/Drug Addiction" addresses non-medical use **only** with respect to substances listed in Schedule I, II, III, IV, or V under Section 202 of the Controlled Substances Act. Include here any diagnosis of substance abuse/dependence based on DSM	

	criteria for a substance listed in Schedule I, II, III, IV, or V of section 202 of the Controlled Substances Act. See CDC's *Technical Instructions* for more information.) [Page 4] **Remarks:** *(Include any therapy given, rehabilitation, counseling, or referrals. Attach a separate sheet of paper (with applicant's name and A-Number) if more space is necessary)* **4. Other Medical Conditions** *(List any other Class B conditions, e.g., hypertension, diabetes.)* **5. Referral to Health Department or Other Doctor** *(To be completed by civil surgeon, if referral was medically required.)* **Type or Print Name of Doctor or Health Department Receiving Required Referral** **Address** *(Street Number and Name, City, State, and Zip Code)* **Date of Referral** *(mm/dd/yyyy)* **Remarks:** *(Include name of medical condition and reasons for referral)*	information. **A. Findings:…** **B. Remarks: (**Include any therapy given, rehabilitation, counseling or referrals. If you need more space, attach a separate sheet of paper; type or print the applicant's name and A-Number (if any), at the top of each sheet; and indicate the **Page Number**, **Part Number**, and **Item Number** to which your answer refers.) **4. Other Medical Conditions** (List any other Class B conditions, such as hypertension or diabetes.) **5. Required Referral to Health Department or Other Doctor** (To be completed by civil surgeon, if referral is medically required. Do not complete if referral is not required, such as recommended referral for LTBI treatment.) **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 name of medical condition and reasons for referral. If you need more space, attach a separate sheet of paper; type or print the applicant's name and A-Number (if any), at the top of each sheet; and indicate the **Page Number**, **Part Number**, and **Item Number** to which your answer refers.
Pages 5,		[Page 8]

CIVIL SURGEON WORKSHEET	**6. Referral Evaluation** *(To be completed by the health department or other doctor performing the referral evaluation.)* The applicant identified on this form was referred to me by the civil surgeon named in **Part 3** 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** **Address** *(Street Number and Name, City, State, and Zip Code)* **Signature** **Date Signed** *(mm/dd/yyyy)* **Name of Medical Practice or Health Department** **Daytime Phone Number** **Remarks:** *(Attach a separate sheet of paper, if needed.)*	**Part 6. 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 4.** of this form. 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. Type or print full name of evaluating physician or health department.** Family Name (Last Name) Given Name (First Name) Middle Name **2. Address** Street Number and Name Apt. Ste. Flr. Number City or Town State ZIP Code **3. Signature** **Date Signed** (mm/dd/yyyy) **4. Name of Medical Practice or Health Department** **5. Daytime Telephone Number** **6. Remarks:** If you need more space, attach a separate sheet of paper; type or print the applicant's name and Alien Registration Number (A-Number) (if any), at the top of each sheet; and indicate the **Page Number**, **Part Number**, and **Item Number** to which your answer refers.
Page 6, **VACCINATION RECORD** *(See Technical Instructions at*		[Page 7] **Part 7. Vaccination Record** (See *Technical Instructions* at **www.cdc.gov/immigrantrefugeehealth/ex**

http://www.cdc.gov/immigrantrefugeehealth/exams/ti/civil/ vaccination-civil-technical-instructions.html for list of required vaccines)	Please make sure every row is marked. Reserve all comments for the Remarks section below. Note: For purposes of the influenza vaccine, the flu season is October 1 through March 31. **For certain applicants who only require a vaccination assessment:** You need only submit this page with Page 1 of Form I-693. See Form Instructions - FAQ section for more information. [Table] [Cell 1] Vaccine History Transferred From a Written Record… [Cell 4] Waiver(s) to Be Requested From USCIS [Cell 11] Blanket [Cell 12] Not Medically Appropriate… Give a Copy to Applicant Results… **Remarks:** *(If needed, provide any remarks: e.g., reason for contraindication)*	**ams/ti/civil/vaccination-civil-technical-instructions.html** for list of required vaccines.) Please make sure to mark every row. Reserve all comments for the Remarks section below. **NOTE:** For purposes of the influenza vaccine, the flu season is October 1 through March 31. **For applicants who only require a vaccination assessment:** Submit only this page with **Part 1., Part 2,** and **Part 4.** of Form I-693 (the applicant, regardless of what is required, may still need an interpreter). For more information, see Form I-693 Instructions, **Section 3.** Frequently Asked Questions. [Table] [Cell 1] Vaccine History Transferred From a Written Record… [New column of cells] Date Received (mm/dd/yyyy)… [Combine cells 4, 11, 12] Blanket Waivers to Be Requested From USCIS (Not Medically Appropriate… **NOTE:** Give a copy to the applicant. **Results…** **Remarks:** (If needed, provide any comments, such as the reason for contraindication.)