TABLE OF CHANGES – FORM
Form I-910, Application for Civil Surgeon Designation
OMB Number: 1615-0114
04/06/2016

Reason for Revision: Incorporate standard language and make other updates

Current Section and Page Number	Current Text	Proposed Text
Page 1, **For USCIS Use Only**	**Initial Receipt** **Resubmitted** **Relocated** (mm/dd/yyyy)	**[Page 1]** **Initial Receipt** (mm/dd/yyyy) **Resubmitted** (mm/dd/yyyy) [Delete]
Page 1, **To Be Completed by an *Attorney or Accredited Representative*, if any.**	**To Be Completed by an *Attorney or Accredited Representative*, if any.** Select the box if Form G-28 is attached to represent the applicant. Attorney State License Number:	**[Page 1]** **To be completed by an attorney or accredited representative** (if any)**.** Select this box if Form G-28 is attached to represent the applicant. Attorney State Bar Number (if applicable) Attorney or Accredited Representative USCIS Online Account Number (if any)
Page 1, **Part 1. For Previously Designated Civil Surgeons**	**Part 1. For Previously Designated Civil Surgeons** **1.a.** Have you ever been designated as a civil surgeon before? If you selected "Yes," provide the following information: **1.b.** Period of Designation *(mm/dd/yyyy)* **1.c.** USCIS Office that granted the designation **1.d.** Civil Surgeon Identification Number *(if known)* **2.a.** Has USCIS ever revoked your designation If you selected "Yes," provide the following information:	**[Page 1]** **Part 1. Information About You** **1.a.** Have you ever been designated as a civil surgeon? If you answered "Yes," provide the following information. [No change] **1.c.** U.S. Citizenship and Immigration Services (USCIS) office that granted the designation **1.d.** Civil Surgeon Identification Number (CSID) (if known) [No change] If you answered "Yes," provide the following information.

	2.b. Date of Revocation *(mm/dd/yyyy)* **3.a.** Have you ever voluntarily terminated your designation? If you selected "Yes," provide the following information: **3.b.** Date of Voluntary Termination *(mm/dd/yyyy)* **NOTE:** If you select "Yes" to **Item Number 2.a.** or **3.a.** above, please include a written explanation of the circumstances surrounding the revocation or voluntary termination, in a separate letter attached to this application or in **Part 10., Additional Information**. **Part 2. Information About You** *(Physician requesting designation or renewal)* **1.a.** Family Name *(Last Name)* **1.b.** Given Name *(First Name)* ***Other Information*** **2.** Date of Birth *(mm/dd/yyyy)*	[No change] [No change] If you answered "Yes," provide the following information. [No change] **NOTE:** If you answered "Yes" to **Item Numbers 2.a.** or **3.a.**, include a typed or printed explanation of the circumstances surrounding the revocation or voluntary termination in **Part 9. Additional Information**. ***Your Full Name*** **4.a.** Family Name (Last Name) **4.b.** Given Name (First Name) **4.c.** Middle Name **Other Names Used** List all other names you have ever used, including aliases, maiden name, and nicknames. If you need extra space to complete this section, use the space provided in **Part 9. Additional Information**. **5.a.** Family Name (Last Name) **5.b.** Given Name (First Name) **5.c.** Middle Name ***Other Information*** **6.** Date of Birth (mm/dd/yyyy) **7.** Gender [] Male [] Female **8.** USCIS Online Account Number (if any)
Page 1, Part 3. Clinical Office Location(s)	**Part 3. Clinical Office Location(s)** Provide the following information about the locations where you seek to perform immigration medical examinations. If you seek to perform immigration medical exams in more than one location, provide the details for each additional location in **Part 10., Additional Information.**	**[Page 1]** **Part 2. Clinical Office Locations** Provide the following information about the locations where you seek to perform immigration medical examinations. If you seek to perform immigration medical exams in more than one location, provide the details for each additional location in the space provided in **Part 9. Additional Information.** **[Page 2]**

	A. Required Information You must provide the following information. Failure to provide this information may result in the denial of your application. Please refer to **Part 3., Section B** for more information about what will be made publicly available. **1.** Name of the Clinic/Practice ***Physical Address of the Clinic/Practice*** **2.a.** Street Number and Name **2.b.** Apt. Ste. Flr. **2.c.** City or town **2.d.** State **2.e.** ZIP Code **3.** Telephone Number **4.** Fax Number **5.** E-Mail Address *(For use by USCIS)* **NOTE:** USCIS will use the contact information listed above for all civil surgeon-related communication. **UPDATE USCIS OF ANY CHANGES:** Civil surgeons are responsible for notifying USCIS in writing of any updates to the contact information provided in this form **within 15 days of the change.** Visit the USCIS web site at **www.uscis.gov/I-910** for information on how to submit a change. ***B. Optional Information*** Providing the following information is optional. Your application will not be affected if you choose not to provide this information. If and when feasible, USCIS may provide this information, in addition to the required information above, as part of the public civil surgeon list. To submit additional information, please check the relevant boxes below and provide the requested details: **1.** E-Mail Address *(For use by the public)* **2.** Web Site Address *(URL)* **3.** Fees for Medical Examination **4.** Acceptable Means of Payment **5.** Languages Spoken **6.** Other	***A. Required Information*** You must provide the following information. Failure to provide this information may result in the denial of your application. Refer to **Part 2., Section B** for more information about what will be made publicly available. [No change] [No change] [No change] [No change] [No change] **5.** Email Address (For use by USCIS) [No change] **UPDATE USCIS OF ANY CHANGES:** Civil surgeons are responsible for notifying USCIS in writing of any updates to the contact information provided in this application **within 15 days of the change.** Visit the USCIS Web site at **www.uscis.gov/I-910** for information on how to submit a change. ***B. Additional Office Information*** Your application will not be affected if you choose not to provide the following information. USCIS displays this information on our Web site for people who want to find a civil surgeon. **6.** Email Address (For use by the public) **7.** Web site Address (URL) **8.** Fees for Medical Examination **9.** Acceptable Means of Payment **10.** Accepted Medical Insurance Plans **11.** Languages Spoken **12.** Office Hours **13.** Handicap Accessibility **14.** Other
Page 2, Part 4. Information About Your Status in the United	**Part 4. Information About Your Status in the**	**[Page 2]** **Part 3. Information About Your Status in**

States	United States	the United States
		You must be authorized to work in the United States to be eligible for civil surgeon designation. Select the box that accurately states how you are authorized to work in the United States.
	1. [] I am a U.S. citizen or national *(Attach proof that you are a U.S. citizen, such as a copy of a U.S. passport, birth certificate, or Certificate of Naturalization.)*	**1.** [] I am a U.S. citizen or national. (Attach proof that you are a U.S. citizen or national, such as a copy of a U.S. passport, birth certificate, or Certificate of Naturalization.)
	2. [] I am a Legal Permanent Resident *(Attach a copy of your valid Form I-551, Permanent Resident Card. If you are currently seeking to extend your Form I-551, attach evidence thereof.)*	**2.** [] I am a Lawful Permanent Resident. (Attach a copy of your valid Form I-551, Permanent Resident Card. If you are currently seeking to renew or replace your Form I-551, attach evidence showing that you are doing so.)
	3. [] I am currently present in the United States as a nonimmigrant *(Provide a copy of your Form I-94 Arrival/Departure Record, a copy of your passport or travel document, and any documents related to your nonimmigrant status, such as a copy of the petition, petition approval, and change or extension of status application.)*	**3.** [] I am currently present in the United States as a nonimmigrant. (Attach a copy of your Form I-94 Arrival-Departure Record, a copy of your passport or travel document, and any documents related to your nonimmigrant status, such as a copy of the petition, petition approval, and change or extension of status application. Also attach a copy of your valid, unexpired Employment Authorization Document as proof of your authorization to work in the United States, if required.)
	3.a. Date of Last Arrival in the U.S. *(mm/dd/yyyy)*	**4.a.** Date of Last Arrival in the U.S. (mm/dd/yyyy)
	3.b. Form I-94 Arrival/ Departure Record Number *(If any)*	**4.b.** Form I-94 Arrival-Departure Record Number (if any)
	3.c. Passport Number	**4.c.** Passport Number
	3.d. Travel Document Number	**4.d.** Travel Document Number
	3.e. Country of Issuance for Passport or Travel Document	**4.e.** Country of Issuance for Passport or Travel Document
	3.f. Expiration Date for Passport or Travel Document *(mm/dd/yyyy)*	**4.f.** Expiration Date for Passport or Travel Document *(mm/dd/yyyy)*
	3.g. Current Nonimmigrant Status	**4.g.** Current Nonimmigrant Status
	4. Other status granted that would allow you to practice medicine in the United States:	**5.** I have been granted another status under U.S. immigration law that allows me to work and to practice medicine in the United States:
Page 3, Part 5. Medical License(s)	**Part 5. Medical License(s)** You must be licensed to practice medicine in	**[Page 3]** **Part 4. Medical Licenses** You must be licensed to practice medicine in

	the state or territory in which you seek to perform immigration medical examinations to be eligible for civil surgeon designation. **Attach a copy of the medical license(s) listed below.** **Medical License 1:** **1.a.** State or U.S. Territory **1.b.** Medical License Number **1.c.** Date Issued *(mm/dd/yyyy)* **1.d.** Date Expires *(mm/dd/yyyy)* **Medical License 2:** **2.a.** State or U.S. Territory **2.b.** Medical License Number **2.c.** Date Issued *(mm/dd/yyyy)* **2.d.** Date Expires *(mm/dd/yyyy)*	the state or territory in which you seek to perform immigration medical examinations to be eligible for civil surgeon designation. **Attach a copy of each medical license listed below.** If you need extra space to complete this section, use the space provided in **Part 9. Additional Information**. **Medical License 1** [No change] [No change] [No change] [No change] **Medical License 2** [No change] [No change] [No change] [No change]
Page 3, **Part 6. Medical Degree(s)**	**Part 6. Medical Degree(s)** You must be a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) to be eligible for civil surgeon designation. **Attach a copy of the medical degree(s) listed below.** **School 1:** **1.a.** School **1.b.** Dates of Attendance *(mm/dd/yyyy)* **1.c.** Degree **School 2:** **2.a.** School **2.b.** Dates of Attendance *(mm/dd/yyyy)* **2.c.** Degree	**[Page 3]** **Part 5. Medical Degrees** You must possess a medical degree as a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) to be eligible for civil surgeon designation. **Attach a copy of each medical degree listed below.** If you need extra space to complete this section, use the space provided in **Part 9. Additional Information**. **School 1** **1.a.** School Name [No change] [No change] **School 2** **2.a.** School Name [No change] [No change]
Page 3, **Part 7. Professional Experience**	**Part 7. Professional Experience** You must establish at least 4 years of professional experience to be eligible for designation. **NOTE:** Time spent in a post-medical school training (including internships or residency programs) cannot be counted toward this experience requirement. **Please attach evidence to verify your professional experience, such as evaluations, certificates of completion, or letters of employment verification.**	**[Page 3]** **Part 6. Professional Experience** You must establish that you have practiced medicine as a physician (M.D. or D.O.) for at least four years to be eligible for designation. **NOTE: In calculating whether you meet the requirement of four years' practice as a physician, DO NOT count your post graduate medical training in an internship or residency program. You can, however, count the time you practiced medicine on the basis of a post-**

		residency fellowship. **Submit evidence to establish your professional experience, such as evaluations, certificates of completion, business tax returns and business license (for self-employed physicians), or letters of employment verification.** If you need extra space to complete this section, use the space provided in **Part 9. Additional Information**.
	Employer 1: **1.a.** Employer **1.b.** Dates of Employment *(mm/dd/yyyy)* **1.c.** Contact Information	**Employer 1** **1.a.** Employer's Name **1.b.** Dates of Employment (mm/dd/yyyy) **1.c.** Street Number and Name **1.d.** Apt. Ste. Flr. Number **1.e.** City or Town **1.f.** State **1.g.** ZIP Code **1.h.** Employer's Daytime Telephone Number **[Page 4]**
	Employer 2: **2.a.** Employer **2.b.** Dates of Employment *(mm/dd/yyyy)* **2.c.** Contact Information	**Employer 2** **2.a.** Employer's Name [No change] **2.c.** Street Number and Name **2.d.** Apt. Ste. Flr. Number **2.e.** City or Town **2.f.** State **2.g.** ZIP Code **2.h.** Employer's Daytime Telephone Number
Page 4, **Part 8. Signature of Applicant**	**Part 8. Signature of Applicant**	**[Page 4]** **Part 7. Applicant's Statement, Contact Information, Certification, and Signature** **NOTE:** Read the **Penalties** section of the Form I-910 Instructions before completing this part. You **must** file Form I-910 while in the United States. ***Applicant's Statement*** **NOTE:** If applicable, select the box for **Item Number 1.** **1.** [] At my request, the preparer named in **Part 8.**, ______________________, prepared this application for me based only upon information I provided or authorized. ***Applicant's Contact Information*** **2.** Applicant's Daytime Telephone Number **3.** Applicant's Mobile Telephone Number (if

		any) **4.** Applicant's Email Address (if any) ***Applicant's Certification***
	By signing this form, I accept civil surgeon designation if my request for designation is granted. Once designated a civil surgeon, I agree that I will perform the medical examinations according to the regulations published by Health and Human Services (HHS) at 42 CFR part 34 and the *Technical Instructions for Civil Surgeons* by the Centers for Disease Control and Prevention (CDC), including periodic updates. By signing this form, I further agree to comply fully with the regulations at 8 CFR part 232. I understand that USCIS reserves the right to revoke civil surgeon designation in certain circumstances.	By signing this application, I accept civil surgeon designation if my request for designation is granted. Once designated as a civil surgeon, I agree that I will perform the medical examinations according to the regulations published by Health and Human Services (HHS) at 42 CFR 34 and the *Technical Instructions for Civil Surgeons* by the Centers for Disease Control and Prevention (CDC), including periodic updates. By signing this application, I further agree to comply fully with the regulations at 8 CFR 232. I understand that USCIS reserves the right to revoke civil surgeon designation in certain circumstances. Copies of any documents I have submitted are exact photocopies of unaltered, original documents, and I understand that USCIS may require that I submit original documents to USCIS at a later date. Furthermore, I authorize the release of any information from any of my records that USCIS may need to determine my eligibility for the designation that I seek. I authorize the release of any information from my records which USCIS deems necessary in order to determine my eligibility for designation as a civil surgeon. I further authorize release of information contained in this application, in supporting documents, and in my USCIS records to other entities and persons where necessary for the administration and enforcement of U.S. immigration laws.
	I certify, under penalty of perjury under the laws of the United States of America, that the information provided with this request is all true and correct. I authorize the release of any information from my records which USCIS deems necessary in order to determine my eligibility for designation as a civil surgeon.	I certify, under penalty of perjury, that I provided or authorized all of the information in my application, I understand all of the information contained in, and submitted with, my application, and that all of this information is complete, true, and correct. ***Applicant's Signature***
	1. Signature of Applicant **2.** Date of Signature *(mm/dd/yyyy)*	**5.a.** Applicant's Signature **5.b.** Date of Signature (mm/dd/yyyy) **NOTE TO ALL APPLICANTS:** If you do not completely fill out this application or fail to submit required documents listed in the Instructions, USCIS may deny your application.

Page 4, Part 9. Signature of Person Preparing This Application, If Other Than Applicant	Part 9. Signature of Person Preparing This Application, If Other Than Applicant	[Page 5] Part 8. Contact Information, Declaration, and Signature of the Person Preparing this Application, if Other Than the Applicant
	Attorney or Representative Only: In the event of a Request for Evidence (RFE), may USCIS contact you by fax or e-mail?	**Attorney or Representative Only:** May USCIS contact you by fax or email if we need to issue a Request for Evidence (RFE)? Yes/No
	Preparer's Information	[Delete]
	Provide the following information concerning the preparer:	Provide the following information about the preparer. [see above]
		Preparer's Full Name
	1.a. Preparer's Family Name *(Last Name)* **1.b.** Preparer's Given Name *(First Name)* **2.** Preparer's Business or Organization Name	**1.a.** Preparer's Family Name (Last Name) **1.b.** Preparer's Given Name (First Name) **2.** Preparer's Business or Organization Name (if any)
		Preparer's Mailing Address
	3.a. Street Number and Name **3.b.** Apt. Ste. Flr. **3.c.** City or Town **3.d.** State **3.e.** ZIP Code	**3.a.** Street Number and Name **3.b.** Apt. Ste. Flr. **3.c.** City or Town **3.d.** State **3.e.** ZIP Code **3.f.** Province **3.g.** Postal Code **3.h.** Country
		[Page 6] ***Preparer's Contact Information***
	4.a. Preparer's Daytime Phone Number **4.b.** Preparer's E-mail Address *(if any)*	**4.** Preparer's Daytime Telephone Number **5.** Preparer's Fax Number **6.** Preparer's Email Address (if any)
	5. Check here if the applicant has authorized you to be a secondary point of contact for communications related to civil surgeon designation.	**7.** [] Select this box if the preparer may act as a secondary point of contact for you. USCIS will contact this preparer if you cannot be reached using the information in **Part 2.**
		Preparer's Statement
		8.a. [] I am not an attorney or accredited representative but have prepared this application on behalf of the applicant and with the applicant's consent. **8.b.** [] I am an attorney or accredited representative and my representation of the applicant in this case [] extends [] does not

	Declaration I declare that this document was prepared by me at the request of the applicant and it is based on all information of which I have knowledge and/or was provided to me by the applicant in response to the exact questions contained on this form. I have not knowingly withheld any information. **6.a.** Signature of Preparer **6.b.** Date of Signature *(mm/dd/yyyy)*	extend beyond the preparation of this application. **NOTE:** If you are an attorney or accredited representative, you may be obliged to submit a completed Form G-28, Notice of Entry of Appearance as Attorney or Accredited Representative, with this application ***Preparer's Certification*** By my signature, I certify, under penalty of perjury, that I prepared this application at the request of the applicant. The applicant then reviewed this completed application and informed me that he or she understands all of the information contained in, and submitted with, his or her application, including the **Applicant's Certification**, and that all of this information is complete, true, and correct. I completed this application based only on information that the applicant provided to me or authorized me to obtain or use. [Delete] ***Preparer's Signature*** **9.a.** Preparer's Signature **9.b.** Date of Signature (mm/dd/yyyy)
Page 5, Part 10. Additional Information	**Part 10. Additional Information** If needed, you may use the space below to provide additional information relevant to this application. Please provide the **Page Number**, **Part Number**, and **Item Number** to which the additional information relates. ***Your Full Name*** **1.a.** Family Name *(Last Name)* **1.b.** Given Name *(First Name)* **2.a.** Page Number **2.b.** Part Number **2.c.** Item Number **2.d.** ___________	**[Page 7]** **Part 9. Additional Information** If you need extra space to provide any additional information within this application, use the space below. If you need more space than what is provided, you may make copies of this page to complete and file with this application or attach a separate sheet of paper. Include your name and CSID Number (if any) at the top of each sheet; indicate the **Page Number**, **Part Number**, and **Item Number** to which your answer refers; and sign and date each sheet. ***Your Full Name*** [no change] [no change] **2.** CSID Number (if any) [Auto-populate field with **Item Number 1.d.** in **Part 1.**] **3.a.** Page Number **3.b.** Part Number **3.c.** Item Number **3.d.** ___________

	3.a. Page Number **3.b.** Part Number **3.c.** Item Number **3.d.** ___________ **4.a.** Page Number **4.b.** Part Number **4.c.** Item Number **4.d.** ___________ **5.a.** Page Number **5.b.** Part Number **5.c.** Item Number **5.d.** ___________ **6.a.** Page Number **6.b.** Part Number **6.c.** Item Number **6.d.** ___________	**4.a.** Page Number **4.b.** Part Number **4.c.** Item Number **4.d.** ___________ **5.a.** Page Number **5.b.** Part Number **5.c.** Item Number **5.d.** ___________ **6.a.** Page Number **6.b.** Part Number **6.c.** Item Number **6.d.** ___________ **7.a.** Page Number **7.b.** Part Number **7.c.** Item Number **7.d.** ___________