OMB No. 1615-0069; Exp. 06/30/2016

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

I-602, Application by Refugee for Waiver of Grounds of Excludability

To be completed by all applicants (Type or print in black ink)

PART 1.

Family Name (in capital letters)	First Name	Middle Name	A-Number

Present Address: Number and Street	City or Town	State	ZIP Code

Date of Birth (mm/dd/yyyy)	Place of Birth (City or Town)	Country of Birth

Country of Citizenship

PART 2.

I have been declared inadmissible or ineligible for adjustment of status under the following section(s) of 212(a) of the Immigration and Nationality Act (INA)**. (NOTE: Sections 212(a)(4), 212(a)(5), and 212(a)(7)(A) do not apply to refugees under Sections 207 or 209 of the INA.)**

I am inadmissible because: (List the specific acts, convictions, or physical or mental conditions. If you have active or suspected tuberculosis, fully complete **Part 3** on **Page 2**. If you have, or have had, a physical or mental disorder, and behavior associated with the disorder that may pose, or has posed, a threat to the property, safety, or welfare of you or others, complete **Part 3A** on **Page 2**.)

I request a waiver of the grounds inadmissibility listed above for the following reasons: *(Check the appropriate block and explain below)*

☐ **For humanitarian reasons** ☐ **To assure family unity** ☐ **In the public interest**

Applicant's Signature: ➡ **Date:**

Do not write below this line *(For USCIS Use Only)*

☐ Waiver of grounds of inadmissibility is granted.

☐ Waiver of grounds of inadmissibility is denied. Basis for Denial:

Date of Action	USCIS Office Director	USCIS Field Office

PART 3. To be completed for applicants with active or suspected tuberculosis or who have or have had a physical or mental disorder and behavior associated with the disorder.

A. Statement by Applicant

Upon admission to the United States I will:

1. Go directly to the physician or health facility named in **Part B** below; and

2. Present copies of diagnostic tests used in the medical examination to substantiate the diagnosis; and

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 I am discharged.

Signature: _____ **Date:** _____

NOTE to Applicant's Sponsor in United States: Arrange for medical care of the applicant and have the physician complete Section B below.

B. Statement by Physician and/or Health Facility

This section of Form I-602 may be executed by a private physician, health department, other public or private health facility, or military hospital. **NOTE:** Upon arrival of the applicant in the United States, Form CDC 75.18, Report on Alien With Tuberculosis Waiver, will be sent to the address given below.

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

I agree to submit Form CDC 75.18 to the health officer named below **(Section C)** either (a) within 30 days of the applicant's reporting for care, indicating presumptive diagnosis, test results, and plans for future care of the applicant; or (b) 30 days after receiving Form CDC 75.18, if the applicant has not reported. (**NOTE:** Military Hospitals should submit this form directly to the Centers for Disease Control, Atlanta, GA 30333.)

Satisfactory financial arrangements have been made. (**NOTE:** This statement does not relieve the applicant of submitting such evidence as the U.S. Consulate may require to establish that the applicant is not likely to become a public charge.)

I represent: *(Check the appropriate box and give the complete name and address of the facility.)*

1. ☐ Local Health Department Outpatient Clinic

2. ☐ Military Hospital

3. ☐ Other Public or Private Health Facility

4. ☐ Private Practice

Signature of Physician: _____ **Date:** _____

Address: *(If military, enter name and address of receiving hospital)*

NOTE to Applicant's Sponsor in United States: If medical care will be provided by a physician who checked Box 3 or 4 in **Section B** above, have **Section C** completed by the local or State health officer who has jurisdiction in the area where the applicant plans to reside in the United States. Provide the health officer with the address where the applicant plans to reside in the United States.

C. Endorsement by 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 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.

Signature: | **Date:**

Enter name and address of the local health department to which Form CDC 75.18, Notice of Arrival of Alien With Tuberculosis Waiver, will be sent when the applicant arrives in the United States.

Local Health Department Address:

USCIS Privacy Act Statement

AUTHORITIES: The information requested on this application, and the associated evidence, is collected under Sections 207 and 209 of the Immigration and Nationality Act, as amended, as well as 8 CFR 207.3.

PURPOSE: The primary purpose for providing the requested information on this application is for a refugee who has been found inadmissible to the United States for reasons such as a criminal conviction or certain health conditions to apply for a waiver of such inadmissibility on grounds of humanitarian reasons, family unity or national interest. DHS will use the information you provide to grant or deny the waiver.

DISCLOSURE: The information you provide is voluntary. However, failure to provide the requested information, and any requested evidence, may delay a final decision or result in denial of the waiver.

ROUTINE USES: DHS may share the information you provide on this application with other Federal, state, local, and foreign government agencies and authorized organizations. DHS follows approved routine uses described in the associated published system of records notices [DHS/USCIS-007 - Benefits Information System and DHS/USCIS-001 - Alien File, Index, and National File Tracking System of Records] which you can find at **www.dhs.gov/privacy**. DHS may also share the information, as appropriate, for law enforcement purposes or in the interest of national security.

Paperwork Reduction Act

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The public reporting burden for this collection of information is estimated at 15 minutes per response, including the time for reviewing instructions and completing and submitting the form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: U.S. Citizenship and Immigration Services, Regulatory Coordination Division, Office of Policy and Strategy, 20 Massachusetts Ave NW., Washington, DC 20529-2140. OMB No. 1615-0069. **Do not mail your application to this address.**