OMB No. 1615-0060; Expires 03/31/2017

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

Form N-648, Medical Certification for Disability Exceptions

ALL parts of this form, except the "APPLICANT ATTESTATION" and "INTERPRETER'S CERTIFICATION" must be certified by a licensed medical professional as provided in the instructions for Form N-648. Before certifying this form, the medical professional must conduct an in-person examination of the applicant. (See instructions for Form N-648 for additional information which is also located in the "FORMS" section at www.uscis.gov.)

Reminder About Eligibility Requirements

This form is intended for an applicant who seeks an exception to the English and/or civics requirements due to a physical or developmental disability or mental impairment that has lasted, or is expected to last, 12 months or more. An applicant who with reasonable accommodations provided under the Rehabilitation Act of 1973 can satisfy the English and civics requirements does not need to submit this form. Reasonable accommodations include, but are not limited to, sign language interpreters, extended time for testing, and off-site testing.

Completing and Certifying This Form

All questions or items must be answered fully and accurately. Responses should utilize common terminology, without abbreviations, that a person without medical training can understand. U.S. Citizenship and Immigration Services (USCIS) recommends that the certifying medical professional use the electronic Form N-648 located in the "FORMS" section www.uscis.gov. If the medical professional completes the form by hand, then responses must be legible and appear in black ink.

Type or print clearly in black ink.

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Part 1. APPLICANT INFORMATION

I certify that I have examined:

Last Name	First Name	Middle Name	USCIS A-Number **A-**
Address (Street Number and Name)			U.S. Social Security Number
City		State or Province	Zip Code or Postal Code
Telephone Number	E-Mail Address (if any)	Date of Birth	Gender ☐ Male ☐ Female

USCIS USE ONLY

This N-648 is:
- ☐ Sufficient
- ☐ Insufficient
- ☐ Continued/RFE

Reviewer

Location & Date

Part 2. MEDICAL PROFESSIONAL INFORMATION

Type or print clearly in black ink. If you need more space to complete an answer, use a separate sheet of paper. Write the applicant's name and Alien Registration Number (A-Number), at the top of each sheet of paper and indicate the part and number of the item to which the answer refers. You must sign and date each continuation sheet. You must answer and complete each question since USCIS will not accept an incomplete Form N-648. You may, but are not required to, attach to this completed form supportive medical diagnostic reports or records regarding the applicant.

NOTE: Only medical doctors, doctors of osteopathy, or clinical psychologists licensed to practice in the United States (including the U.S. territories of Guam, Puerto Rico, and the Virgin Islands) are authorized to certify the form. While staff of the medical practice associated with the medical professional certifying the form may assist in its completion, the medical professional is responsible for the accuracy of the form's content.

Last Name	First Name		Middle Name	
Business Address (Street Number and Name)	City	State or Province	Zip Code or Postal Code	Telephone Number
License Number	Licensing State	E-Mail Address (if any)		

1. Currently licensed as a *(Check all that apply):* ☐ Medical Doctor ☐ Doctor of Osteopathy ☐ Clinical Psychologist

2. Medical practice type: _____

Applicant's Name	USCIS A-Number **A-**

Part 3. INFORMATION ABOUT DISABILITY and/or IMPAIRMENT(S)

1. Provide the clinical diagnosis of the applicant's disability and/or impairment, that form the basis for seeking an exception to the English and/or civics requirements. If applicable, please provide the relevant medical code as accepted by the Department of Health and Human Services (HHS). This includes the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD). For example, DSM-V 318.1 Intellectual Disability (Severe) or 2015/16 ICD-10-CM F72 Severe intellectual disabilities.

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2. Provide a basic description of the disability and/or impairment(s), for example, Intellectual Disability (Severe) is a genetic disorder that causes lifelong intellectual disability, developmental delays, and other problems.

3. Date you first examined the applicant regarding the condition(s) listed in number 1.

Date *(mm/dd/yyyy)*	Location (if different from business address on Page 1; otherwise write "same as business address")

4. Date you last examined the applicant regarding the condition(s) listed in number 1, if different from above.

Date *(mm/dd/yyyy)*	Location (if different from business address on Page 1; otherwise write "same as business address")

5. Are you the medical professional regularly treating this applicant for the condition(s) listed in Item Number 1?

☐ Yes *(If "Yes," indicate duration of treatment.)* Years _____ Months _____

☐ No *(If "No," provide the name of the applicant's regularly treating medical professional on the next page and explain why you are certifying this form instead of the regularly treating medical professional.)*

Applicant's Name	USCIS A-Number **A-**

Name of Regularly Treating Medical Professional and Address.

Last Name	First Name		Middle Name	
Business Address (Street Number and Name)	City	State or Province	Zip Code or Postal Code	Telephone Number

Explanation

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6. Has the applicant's disability and/or impairment(s) lasted, or do you expect it to last, 12 months or more?

☐ Yes *(If "Yes,"continue to complete this form.)*

☐ No *(If "No," the applicant is not eligible for this exception and you need not complete the remainder of the questions. Please go directly to the "Medical Professional's Certification.")*

7. Is the applicant's disability and/or impairment(s) the result of the applicant's illegal use of drugs?

☐ Yes *(If "Yes," the applicant is not eligible for this exception and you need not complete the remainder of the questions. Please go directly to the "Medical Professional's Certification.")*

☐ No *(If "No," continue to complete this form.)*

8. What caused this applicant's medical disability and/or impairment(s) listed in number 1, if known?

Applicant's Name	USCIS A-Number **A-**

9. What clinical methods did you use to diagnose the applicant's medical disability and/or impairment(s) listed in number 1?

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10. Clearly describe how the applicant's disability and/or impairment(s) affect his or her ability to demonstrate knowledge and understanding of English and/or civics.

11. In your professional medical opinion, does the applicant's disability or impairment(s) prevent him or her from demonstrating the following requirements? *(Check all that apply. If none applies, the applicant is not eligible for this exception.)*

The ability to:

- ☐ Read English
- ☐ Write English
- ☐ Speak English
- ☐ Answer questions regarding United States history and civics, even in a language the applicant understands.

Applicant's Name	USCIS A-Number **A-**

12. Was an interpreter used during your examination of the applicant?

☐ Yes *(If "Yes," the interpreter must complete the "Interpreter Certification" section.)*

☐ No

Additional Comments *(Optional)*

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MEDICAL PROFESSIONAL' S CERTIFICATION

Complete the following if an interpreter was not used during your examination of the applicant between the applicant and medical professional pertaining to the examination(s) that form the basis of this Form N-648 certification.

I am fluent in English and _____, the language spoken by this patient. Therefore, an interpreter was not used during my examination(s) of this applicant.

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All medical professionals **must** complete the certification below.

I certify that this applicant's identity has been verified through the following United States or State government-issued photographic identity document:

☐ Permanent Resident Card ☐ State ID Number: _____

☐ Other Identification (State type and ID Number): _____

I certify, under penalty of perjury under the laws of the United States of America, that the information on this form and any evidence submitted with it are all true and correct. I will furnish relevant medical records to USCIS, if requested to do so by USCIS, based on the applicant's consent. I am aware that the knowing placement of false information on Form N-648 and related documents may also subject me to criminal penalties including under Title 18, U.S.C. Section 1546, civil penalties under Title 18, U.S.C. Section 247c of the Immigration and Nationality Act, and civil license suspension or revocation by the appropriate authorities.

Licensed Medical Professional Signature **Date** *(mm/dd/yyyy)*

_____ _____

Applicant's Name	USCIS A-Number **A-**

INTERPRETER'S CERTIFICATION

An interpreter must complete, and certify, the section below if an interpreter translated communications between the applicant and medical professional on the day of the examination that formed the basis of this Form N-648 certification.

Interpreter Information

Last Name	First Name	Middle Name		
Address (Street Number and Name)	City	State or Province	Zip Code or Postal Code	

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Was a phone interpreter used?

☐ Yes *(If yes, the interpreter is not required to complete the information below.)*

☐ No *(If no, the interpreter is required to complete the information below.)*

NOT FOR

Interpreter Certification

I am fluent As the interpreter, I certify that I am fluent in English and the following language: _____ .
I further certify that I have accurately and completely translated all communications between the medical professional and the applicant that occurred on _____, the date(s) of the examination(s) that form the basis of this certification.

Interpreter Signature **Date** *(mm/dd/yyyy)*

_____

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APPLICANT (PATIENT) ATTESTATION/RELEASE OF INFORMATION

I, _____, authorize _____
(Applicant's Name) (Licensed medical doctor, doctor of osteopathy, or clinical psychologist)

01/12/2017

to release to U.S. Citizenship and Immigration Services all relevant physical and mental health information related to my medical status for the purpose of applying for an exception from the English language and U.S. civics requirements for naturalization. I certify under penalty of perjury, pursuant to Title 28, U.S.C. Section 1746, that the information I provided to the medical professional is true and correct. I am aware that the knowing placement of false information on Form N-648 and related documents may also subject me to civil penalties under Title 8, U.S.C. Section 1324c. I understand that if this form is not completely filled out or if I fail to submit any required documentation, I may not be found eligible for the requested disability exception.

Applicant or Applicant's Authorized Representative Signature **Date** *(mm/dd/yyyy)*

_____ _____