Medical Certification for Disability Exceptions

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

USCIS
Form N-648
OMB No. 1615-0069
Expires 05/31/2019

► **START HERE - Type or print in black ink.**

Please read the instructions before examining the applicant and filling out this form.

Only medical doctors, doctors of osteopathy, or clinical psychologists licensed to practice in the United States (including the U.S. territories of the Commonwealth of the Northern Mariana Islands (CNMI), 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. Failure to fully and accurately complete this form, including all applicable signatures, may result in the form being found insufficient.

If you are using an interpreter during the examination (either in person or by phone), you must ask the interpreter the following questions and affirm their response:

- Do you certify that you are fluent in English and the following language, _____ ,
- Do you further certify that you will accurately and completely interpret all communications between the applicant _____ and me (the medical professional)?

Part 1. Applicant Information

I certify that I have examined the following applicant.

USCIS USE ONLY

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

Reviewer

Location & Date

1. Applicant's Legal Name

Family Name (Last Name)

Given Name (First Name)

Middle Name (if any)

2. Applicant's Current Physical Address *(USPS ZIP Code Lookup)*

Street Number and Name

Apt. Ste. Flr. Number

City or Town

State

ZIP Code

Province

Postal Code

Country

Applicant's Other Information

3. Alien Registration Number (A-Number) (if any)

► **A-**

4. U.S. Social Security Number (if any)

►

5. Date of Birth (mm/dd/yyyy)

6. Gender

☐ Male ☐ Female

7. Applicant's Telephone Number

8. Applicant's Email Address (if any)

Part 2. Medical Professional Information

1. Medical Professional's Name

Family Name (Last Name) | Given Name (First Name) | Middle Name (if any)

2. Medical Professional's Business Address

Street Number and Name | Apt. Ste. Flr. | Number

City or Town | State | ZIP Code

Province | Postal Code | Country

3. License Number

4. Licensing State

5. Business Telephone Number

6. Email Address (if any)

7. I am currently licensed as a (select all that apply):

☐ Medical Doctor ☐ Doctor of Osteopathy ☐ Clinical Psychologist

8. Medical Practice Type:

Part 3. Information About Disabilities and/or Impairments

1. Provide the clinical diagnosis of **all** physical or developmental disabilities and/or mental impairments that may affect the applicant's ability to demonstrate an understanding of the English language and/or a knowledge and understanding of the fundamentals of the history and the principles and form of government of the United States. 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."

Part 3. Information About Disabilities and/or Impairments (continued)

2. Provide a basic description of all the disabilities and/or impairments listed in **Part 3**, **Item 1**. For example, "Intellectual Disability (Severe) is a genetic disorder that causes lifelong intellectual disability, developmental delays, and other problems."

3. When did each disability or impairment listed in **Part 3.**, **Item Number 1.**, begin?

Date (mm/dd/yyyy) _____ If you need extra space to complete this section, use the space provided below.

4. Date(s) of Diagnosis (mm/dd/yyyy) _____ _____

If you need extra space to complete this section, use the space provided below.

5. What caused each of this applicant's medical disabilities and/or impairments listed in **Part 3.**, **Item Number 1.**, if known?

Part 3. Information About Disabilities and/or Impairments (continued)

6. What clinical methods did you use to diagnose each of the applicant's medical disabilities and/or impairment(s) listed in **Part 3., Item Number 1.**?

7. Describe the severity of each disability and/or impairment listed in **Part 3., Item Number 1.** Explain the basis of your assessment, i.e. known symptoms of condition, tests conducted, observations, etc.

8. Describe how each relevant disability and/or impairment affects specific functions of the applicant's daily life, including the ability to work or go to school, that may be related to the ability to learn civics and/or English, including the ability to read, write and speak words in ordinary usage of the English language. Explain the basis of your assessment, including known symptoms of condition, tests conducted, observations, etc.

9. Have any of the applicant's disabilities and/or impairments lasted, or do you expect any of them to last, 12 months or more?

☐ Yes ☐ No

Part 3. Information About Disabilities and/or Impairments (continued)

10. Provide an explanation as to which disabilities or impairments are expected to last over 12 months and why.

NOTE: If you answered "No," the applicant is not eligible for this exception and you need to go directly to **Part 6. Medical Professional's Certification**.

11. Are any of the disabilities and/or impairment(s) the result of the applicant's illegal use of drugs?

☐ Yes ☐ No

12. If yes, provide an explanation as to which disabilities or impairments are the result of the applicant's illegal use of drugs.

NOTE: If you answered "Yes" and all of the applicant's disabilities and/or impairments are the result of the applicant's illegal use of drugs, the applicant is not eligible for this exception and you need to go directly to **Part 6. Medical Professional's Certification**.

13. Clearly describe how each of the applicant's disabilities and/or impairments affects his or her ability to demonstrate knowledge and understanding of English and/or civics.

14. In your professional medical opinion, do any of the applicant's disabilities or impairments prevent him or her from demonstrating the following requirements? (Select all that apply. If none applies, the applicant is not eligible for this exception.)

The ability to: ☐ Read English ☐ Speak English ☐ Write English

☐ Answer questions regarding United States history and civics, even in a language the applicant understands.

15. Date and location you first examined the applicant regarding the condition(s) listed in **Part 3., Item Number 1.**

A. Date (mm/dd/yyyy) ☐

Part 3. Information About Disabilities and/or Impairments (continued)

B. Location (if different from business address provided in **Part 2.**, otherwise select "same as business address").

☐ Same as business address

Street Number and Name | Apt. Ste. Flr. | Number

City or Town | State | ZIP Code

Province | Postal Code | Country

16. Date and location you last examined the applicant regarding the conditions listed in **Part 3.**, **Item Number 1.**, if different from above.

A. Date (mm/dd/yyyy)

B. Location (if different from business address provided in **Part 2.**, otherwise select "same as business address").

☐ Same as business address

Street Number and Name | Apt. Ste. Flr. | Number

City or Town | State | ZIP Code

Province | Postal Code | Country

17. Are you the medical professional who regularly treats this applicant for the conditions listed in **Part 3.**, **Item Number 1.**?

☐ Yes ☐ No

18. If you answered "Yes," indicate the duration of treatment and skip **Item Number 20. - 22.**

Years ☐ Months ☐ ☐ Yearly

19. Please indicate the frequency of treatment.

☐ Weekly ☐ Monthly ☐ Yearly ☐ Other

20. Name of Regularly Treating Medical Professional

Family Name (Last Name) | Given Name (First Name) | Middle Name (if applicable)

21. Business Address and Phone Number of Regularly Treating Medical Professional

Street Number and Name | Apt. Ste. Flr. | Number

City or Town | State | ZIP Code

Province | Postal Code | Country

Part 3. Information About Disabilities and/or Impairments (continued)

22. Explanation for why you are certifying this form instead of the regularly treating medical professional.

23. Did you use an interpreter when you examined the applicant?

☐ Yes ☐ No

NOTE: If you answered "Yes," the interpreter must complete **Part 4. Interpreter's Certification**. If you used a telephonic interpreter, please complete all **Items** in **Part 4. except Item Numbers 6.** and **7.**

Additional Comments (Optional)

Part 4. Interpreter's Certification

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

1. Interpreter's Name

Family Name (Last Name) | Given Name (First Name) | Middle Name (if applicable)

2. Interpreter's Mailing Address

Street Number and Name | Apt. Ste. Flr. | Number

City or Town | State | ZIP Code

Province | Postal Code | Country

Interpreter's Contact Information

3. Interpreter's Daytime Telephone Number

4. Interpreter's Mobile Telephone Number (if any)

5. Interpreter's Email Address (if any)

Part 4. Interpreter's Certification (continued)

Interpreter's Certification

6. I certify that I am fluent in English and the following language, _____. I further certify that I have accurately and completely interpreted all communications between the medical professional and the applicant that occurred on _____, the dates of the examinations that form the basis of this certification.

7. Interpreter's Signature _____ Date of Signature (mm/dd/yyyy) _____

Certification for Telephonic Interpreter (to be completed by the medical professional)

8. Was a telephonic interpreter used during the examination of the applicant?

☐ Yes (go to question 9.) ☐ No

9. If you answered yes, did you ask the interpreter to affirm that he or she speaks fluent English and the applicant's language and that he or she will accurately and completely interpret all communications between you and the applicant?

☐ Yes ☐ No

10. If yes, did the interpreter answer in the affirmative?

☐ Yes ☐ No

Part 5. Applicant's (Patient's) Attestation/Release of Information

1. I, _____ (Applicant's Name), authorize _____ (Licensed medical doctor, doctor of osteopathy, or clinical psychologist) 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 28 U.S.C. section 1746, that the information I provided to the medical professional is true and correct. I certify under penalty of perjury, pursuant to 28 U.S.C. section 1746, that I have attended an appointment with _____ (Licensed medical doctor, doctor of osteopathy, or clinical psychologist) and was then diagnosed by him or her. 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 8 U.S.C. section 1324c and INA section 274C. I understand that if this form is not completely filled out or if I fail to submit any required documentation, I may be found ineligible for the requested disability exception.

2. Applicant or Applicant's Authorized Representative's Signature _____ Date of Signature (mm/dd/yyyy) _____

Part 6. Medical Professional's Certification

Complete the following if you did not use an interpreter to communicate with the applicant during the examinations that form the basis of this Form N-648.

1. I did not use an interpreter during my examinations of this applicant because:

☐ I am fluent in English and _____, the language spoken by this applicant.

☐ This applicant speaks English.

Part 6. Medical Professional's Certification (continued)

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

2. 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 (Indicate 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 18 U.S.C. section 1546, civil penalties under 8 U.S.C. section 1324c and Immigration and Nationality Act (INA) section 274C, and civil license suspension or revocation by the appropriate authorities.

3. Licensed Medical Professional Signature _____ Date of Signature (mm/dd/yyyy) _____