TABLE OF CHANGES – FORM
Form N-648, Medical Certification for Disability Exceptions
OMB Number: 1615-0060
10/04/2019

Reason for Revision: Additional collections related to the applicant's disabilities and/or impairments, and the medical examinations

Legend for Proposed Text:
- Black font = Current text
- Red font = Changes

Expires 05/31/2021
Edition Date 05/23/2019

Current Page Number and Section	Current Text	Proposed Text
Page 1	**[Page 1]** **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	**[Page 1]** **[Delete]**

	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. **[New]**	**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	**[Page 1]** **Type or print clearly in black ink.** **Part 1. APPLICANT INFORMATION** **I certify that I have examined:** Last Name First Name Middle Name USCIS A-Number Address (Street Number and Name) U.S. Social Security Number	**[Page 1]** **[Delete]** **Part 1. Applicant Information** I certify that I have examined the following applicant. **1.** Applicant's Legal Name Family Name (Last Name) Given Name (First Name) Middle Name (if any) [moved down] **2.** Applicant's Current Physical Address Street Number and Name

	City State or Province Zip Code or Postal Code Telephone Number E-Mail Address (if any) Date of Birth Gender	[moved down] 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) **4.** U.S. Social Security Number (if any) **5.** Date of Birth (mm/dd/yyyy) **6.** Gender (M/F) **7.** Applicant's Telephone Number **8.** Applicant's Email Address (if any)
Part 2. MEDICAL PROFESSIONAL INFORMATION	**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. Type or print 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	**[Page 2]** **Part 2. Medical Professional Information** [Delete] **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

	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:**	Postal Code Country ***Medical Professional's Other Information*** **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 DISABILITY and/or IMPAIRMENT(S)	**[Page 2]** **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.** [Fillable box with lines] **2. Provide a basic description of the disability and/or impairments, for example, Intellectual Disability (Severe) is a genetic disorder that causes lifelong intellectual disability, developmental delays, and other problems.** [Fillable box with lines] **[New]**	**[Page 2]** **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." [Fillable box with lines] **[Page 3]** **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." [Fillable box with lines] **3.** When did each disability or impairment listed in **Part 3**, **Item 1**, begin? Date (mm/dd/yyy) If you need extra space to complete this section, use the space provided in below. [Fillable box with lines]

		4. Date(s) of Diagnosis. mm/dd/yyyy If you need extra space to complete this section, use the space provided below. [Fillable box with lines] **5.** What caused each of this applicant's medical disabilities and/or impairments listed in **Part 3.**, **Item Number 1.**, if known? [Fillable box with lines] **[Page 4]** **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.**? [Fillable box with lines] **7.** Describe the severity of each disability and/or impairment listed in **Part 3**, **Item 1**. Explain the basis of your assessment, i.e. known symptoms of condition, tests conducted, observations, etc. [Fillable box with lines] **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. [Fillable box with lines]
	6. Has the applicant's disability and/or impairments 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.")	**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 **[Page 5]** **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

	7. Is the applicant's disability and/or impairments the result of the applicant's illegal use of drugs? Yes **[New]** (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 impairments listed in number 1, if known?** [Fillable box with lines] **[Page 4]** **9. What clinical methods did you use to diagnose the applicant's medical disability and/or impairments listed in number 1?** [Fillable box with lines] **10. Clearly describe how the applicant's disability and/or impairments affect his or her ability to demonstrate knowledge and understanding of English and/or civics.** [Fillable box with lines] **11. In your professional medical opinion, does the applicant's disability or impairments 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.	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. [Fillable box with lines] **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. [Fillable box with lines] **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 Write English Speak English Answer questions regarding United States history and civics, even in a language the applicant understands.

	3. Date you first examined the applicant regarding the conditions listed in number 1. Date (mm/dd/yyyy) Location (if different from business address on Page 1; otherwise type or print "same as business address") **4. Date you last examined the applicant regarding the conditions listed in number 1, if different from above.** Date (mm/dd/yyyy) Location (if different from business address on Page 1; otherwise type or print "same as business address") **5. Are you the medical professional regularly treating this applicant for the conditions 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.)	**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) **[Page 6]** **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 **Items 20. -22.** Years Months **[Delete]** **19.** Please indicate the frequency of treatment.

		Weekly Monthly Yearly Other: (text box)
	[Page 3] **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** [Fillable box with lines]	**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 Telephone Number **[Page 7]** **22.** Explanation for why you are certifying this form instead of the regularly treating medical professional. [Fillable box with lines]
	[Page 5] **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) [Fillable box with lines]	**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) [Fillable box with lines]
MEDICAL PROFESSIONAL' S	**MEDICAL PROFESSIONAL' S CERTIFICATION**	**[Moved to end of form]**

CERTIFICATION		
INTERPRETER'S CERTIFICATION	**[Page 6]** **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. **Interpreter Information** Last Name First Name Middle Name Address (Street Number and Name) City State or Province Zip Code or Postal Code **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.) **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 dates of the examinations that form the basis of this certification. **Interpreter Signature** **Date** (mm/dd/yyyy)	**[Page 7]** **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. **[Delete]** **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 **[Moved down]** ***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) **[Page 8]** **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
APPLICANT (PATIENT) ATTESTATION/RELEASE OF INFORMATION	**APPLICANT (PATIENT) ATTESTATION/RELEASE OF INFORMATION** 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 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 not be found eligible for the requested disability exception. **Applicant or Applicant's Authorized Representative Signature** **Date** (mm/dd/yyyy)	**[Page 8]** **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)
MEDICAL PROFESSIONAL' S CERTIFICATION	**MEDICAL PROFESSIONAL' S CERTIFICATION**	**[Page 9]** **Part 6. Medical Professional's Certification** Complete the following if you did not use an

	Complete the following if an interpreter was not used during your examination of the applicant between the applicant and medical professional pertaining to the examinations that form the basis of this Form N-648.	interpreter to communicate with the applicant during the examinations that form the basis of this Form N-648.
	I am fluent in English and ____, the language spoken by this patient. Therefore, an interpreter was not used during my examinations of this applicant.	**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
	All medical professionals **must** complete the certification below.	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 (Indicate type and ID Number):	**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.	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.
	Licensed Medical Professional Signature Date (mm/dd/yyyy)	**3.** Licensed Medical Professional Signature Date of Signature (mm/dd/yyyy)