

TABLE OF CHANGES –FORM
Form N-648, Medical Certification for Disability Exceptions
OMB Number: 1615-0060
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Project Phase: 30 Day

Legend for Proposed Text:

- Black font = Current text
- **Red font** = Changes

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Current Page Number and Section	Current Text	Proposed Text
Page 1	<p>[Page 1]</p> <p>START HERE - Type or print in black ink.</p> <p>Please read the instructions before examining the applicant and filling out this form.</p> <p>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.</p> <p>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:</p> <p>Do you certify that you are fluent in English and the following language, [Fillable field]? Do you further certify that you will accurately and completely interpret all communications between the applicant [Fillable field] and me (the medical professional)?</p>	<p>[Page 1]</p> <p>START HERE - Type or print in black ink.</p> <p>Please read the instructions before examining the applicant and filling out this form.</p> <p>In general, applicants for naturalization must demonstrate that they understand the English language, including the ability to read, write, and speak words in ordinary usage. They must also demonstrate knowledge and understanding of the fundamentals of the history, principles, and form of government of the United States. These are called the “English and civics requirements.” This form is used for applicants to seek an exception to the English and civics requirements due to a physical or developmental disability or mental impairment that has lasted, or is expected to last, 12 months or more. Applicants seeking such an exception should submit this form as an attachment to the Form N-400, Application for Naturalization.</p> <p>Please note:</p> <ul style="list-style-type: none"> • Only medical doctors, doctors of osteopathy, or clinical psychologists can certify the form. • Additionally, they must be licensed to practice in the United States (including the U.S. territories of the Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the Virgin Islands) to certify the form.

		<ul style="list-style-type: none"> • While staff of the medical practice associated with the certifying medical professional certifying the form may assist in its completion, the certifying medical professional is responsible for the accuracy of the form's content and therefore must sign it. • Answer all the questions regarding medical information, using common terminology that a person without medical training can understand, with no abbreviations. Failure to fully and accurately complete this form, including all applicable signatures, may result in the form being found insufficient.
<p>Page 1, Part 1. Applicant Information</p>	<p>[Page 1]</p> <p>Part 1. Applicant Information</p> <p>I certify that I have examined the following applicant.</p> <ol style="list-style-type: none"> 1. Applicant's Legal Name Family Name (Last Name) Given Name (First Name) Middle Name (if any) 2. Applicant's Current Physical Address Street Number and Name Apt./Ste./Flr./Number City or Town State ZIP Code Province Postal Code Country <p><i>Applicant's Other Information</i></p> <ol style="list-style-type: none"> 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) 	<p>[Page 1]</p> <p>Part 1. Applicant Information</p> <p>[deleted]</p> <ol style="list-style-type: none"> 1. Applicant's Legal Name Family Name (Last Name) Given Name (First Name) Middle Name (if any) <p>[deleted]</p> <ol style="list-style-type: none"> 2. Alien Registration Number (A-Number) (if any) 3. Date of Birth (mm/dd/yyyy) <p>[deleted]</p>
<p>Page 2, Part 2. Medical Professional Information</p>	<p>[Page 2]</p> <p>Part 2. Medical Professional Information</p> <ol style="list-style-type: none"> 1. Medical Professional's Name Family Name (Last Name) Given Name (First Name) Middle Name (if any) 	<p>[Page 1]</p> <p>Part 2. Certifying Medical Professional Information</p> <ol style="list-style-type: none"> 1. Certifying Medical Professional's Name Family Name (Last Name) Given Name (First Name) Middle Name (if any)

	<p>2. Medical Professional’s Business Address</p> <p>Street Number and Name Apt./Ste./Flr./Number City or Town State ZIP Code Province Postal Code Country</p> <p>3. License Number 4. Licensing State 5. Business Telephone Number 6. Email Address (if any)</p> <p>7. I am currently licensed as a (select all that apply): Medical Doctor Doctor of Osteopathy Clinical Psychologist</p> <p>8. Medical Practice type: [fillable field]</p> <p>[new]</p>	<p>[Page 2]</p> <p>2. Certifying Medical Professional’s Business Address Street Number and Name Apt./Ste./Flr./Number City or Town State ZIP Code Province Postal Code Country</p> <p>[no change]</p> <p>9. Did you use an interpreter: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. If No, I did not use an interpreter because: <input type="checkbox"/> I am fluent in English and [fillable field], the language spoken by this applicant. <input type="checkbox"/> This applicant speaks English.</p>
<p>Page 2-7, Part 3. Information About Disabilities and/or Impairments</p>	<p>[Page 2]</p> <p>Part 3. Information About Disabilities and/or Impairments</p> <p>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]</p>	<p>[Page 2]</p> <p>Part 3. Information About Disabilities and/or Impairments</p> <p>1. Provide the clinical diagnosis and medical code for all physical or developmental disabilities and/or mental impairments that affect the applicant’s ability to meet the English and/or civics requirements. Also, clearly describe how each disability and/or impairment prevents the applicant from learning English and/or civics. Responses should use common terminology, without abbreviations, that a person without medical training can understand. Refer to page 2 of the Instructions for an example. Please provide the relevant medical code as accepted by the U.S. 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 “2022 ICD-10-CM F72 Severe intellectual disabilities.” [Fillable box with lines]</p>

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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/yyyy) 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]

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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]

[deleted]

[Page 4]

2. What clinical or laboratory diagnostic techniques did you use to diagnose each of the applicant’s disabilities and/or impairment(s) listed in **Part 3., Item Number 1.**?

[Fillable box with lines]

[deleted]

	<p>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</p> <p>[Page 5]</p> <p>10. Provide an explanation as to which disabilities or impairments are expected to last over 12 months and why.</p> <p>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.</p> <p>11. Are any of the disabilities and/or impairment(s) the result of the applicant’s illegal use of drugs? Yes No</p> <p>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]</p> <p>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.</p> <p>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]</p> <p>[new]</p> <p>14. In your professional medical opinion, do any of the applicant’s disabilities or impairments prevent him or her from demonstrating the following requirements?</p>	<p>3. Have any of the applicant’s disabilities and/or impairments listed in Part 3., Item Number 1. lasted, or do you expect any of them to last, 12 months or more? If your answer is “No,” do not complete this form because the applicant is not eligible for this exception. Yes No</p> <p>[deleted]</p> <p>4. Are any of the disabilities and/or impairment(s) listed in Part 3., Item Number 1. the result of the applicant’s illegal use of drugs? If your answer is “Yes” for all of the disabilities or impairments, do not complete this Form because the applicant is not eligible for this exception. Yes No</p> <p>5. If yes, for some disabilities or impairments, identify which disabilities or impairments are the result of the applicant’s illegal use of drugs. [Fillable box with lines]</p> <p>[deleted]</p> <p>6. For disabilities and/or impairments listed in Part 3., Item Number 1., provide the date you last examined the applicant. Date (mm/dd/yyyy)</p> <p>7. Do any of the disabilities or impairments listed in Part 3., Item Number 1. prevent the applicant from demonstrating the following? Select all that apply. If none applies, do not</p>
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	<p>(Select all that apply. If none applies, the applicant is not eligible for this exception.)</p> <p>The ability to: Read English Write English Speak English Answer questions regarding United States history and civics, even in a language the applicant understands.</p> <p>[new]</p> <p>15. Date and location you first examined the applicant regarding the condition(s) listed in Part 3., Item Number 1.</p> <p>A. Date (mm/dd/yyyy)</p> <p>[Page 6]</p> <p>B. Location (if different from business address provided in Part 2., otherwise select “same as business address”)</p> <p><input type="checkbox"/> Same as business address Street Number and Name Apt./Ste./Flr./Number City or Town State ZIP Code Province Postal Code Country</p> <p>16. Date and location you last examined the applicant regarding the conditions listed in Part 3., Item Number 1., if different from above.</p> <p>A. Date (mm/dd/yyyy)</p> <p>B. Location (if different from business address provided in Part 2., otherwise select “same as business address”)</p> <p><input type="checkbox"/> Same as business address Street Number and Name Apt./Ste./Flr./Number City or Town State ZIP Code Province Postal Code Country</p>	<p>complete this Form because the applicant is not eligible for this exception.</p> <p>The ability to: <input type="checkbox"/> Read English <input type="checkbox"/> Write English <input type="checkbox"/> Speak English <input type="checkbox"/> Answer questions regarding United States history and civics, even in a language the applicant understands.</p> <p>8. Is this applicant unable to understand or communicate that they understand the meaning of the Oath of Allegiance to the United States, because of the disabilities or impairments listed in Part 3., Item Number 1. even in a language the applicant understands? Yes No</p> <p>[deleted]</p>
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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
Yearly

19. Please indicate the frequency of treatment.

Weekly
Monthly
Yearly
Other: (text box)

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

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

[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]

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		<p>Part 4. Ability to Understand Oath of Allegiance</p> <p>The applicant will not be able to naturalize without a legal guardian, surrogate, or an eligible designated representative unless they are able to understand and communicate that they understand the meaning of the Oath of Allegiance. The Oath may be administered in the applicant’s language of choice and they may communicate their understanding in any manner (for example, by nodding).</p> <p>1. Is the applicant able to understand and communicate that they understand the meaning of the Oath of Allegiance to the United States? Yes No</p>
<p>Page 7-8,</p> <p>Part 4. Interpreter’s Certification</p>	<p>[Page 7]</p> <p>Part 4. Interpreter’s Certification</p> <p>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.</p> <p>[new]</p> <p>1. Interpreter’s Name Family Name (Last Name) Given Name (First Name) Middle Name (if applicable)</p> <p>2. Interpreter’s Mailing Address Street Number and Name Apt./Ste./Flr./Number City or Town State ZIP Code Province Postal Code Country</p>	<p>[Page 4]</p> <p>Part 5. Interpreter Information and Certification</p> <p>[deleted]</p> <p>If in-person interpretation services were used during the medical examination, the interpreter must fill out this section, sign, and date the certification. If telephonic interpretation services were used during the medical examination, the certifying medical professional must complete all items in this section, except Item Number 6.</p> <p>1. Was a telephonic or video facilitated interpreter used during the examination of the applicant? Yes No</p> <p>2. Interpreter’s Name Family Name (Last Name) Given Name (First Name) Middle Name (if applicable)</p> <p>[deleted]</p>

	<p>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)</p> <p>[Page 8]</p> <p>Interpreter's Certification</p> <p>6. I certify that I am fluent in English and the following language, [fillable field]. I further certify that I have accurately and completely interpreted all communications between the medical professional and the applicant that occurred on [fillable field], the dates of the examinations that form the basis of this certification.</p> <p>7. Interpreter's Signature Date of Signature (mm/dd/yyyy)</p> <p>Certification for Telephonic Interpreter (to be completed by the medical professional)</p> <p>8. Was a telephonic interpreter used during the examination of the applicant? Yes (go to question 9.) No</p> <p>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</p> <p>10. If yes, did the interpreter answer in the affirmative? Yes No</p>	<p>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)</p> <p>Interpreter's Certification</p> <p>I certify that I am fluent in English and the following language, [fillable field]. I further certify that I have accurately and completely interpreted all communications between the certifying medical professional and the applicant that occurred on [fillable field], the date(s) of the examination(s) that form the basis of this certification.</p> <p>6. Interpreter's Signature (not required for telephonic interpretations) Date of Signature (mm/dd/yyyy)</p> <p>[deleted]</p>
<p>Page 8, Part 5. Applicant's (Patient's) Attestation/Release of Information</p>	<p>[Page 8] Part 5. Applicant's (Patient's) Attestation/Release of Information</p> <p>1. I, [fillable field] (Applicant's Name), authorize [fillable field] (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</p>	<p>[Page 4] Part 6. Applicant's (Patient's) Attestation/Release of Information</p> <p>1. I, [fillable field] (Applicant's Name), authorize [fillable field] (the Licensed medical doctor, doctor of osteopathy, or clinical psychologist completing this form) to release to U.S. Citizenship and Immigration Services (USCIS) 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</p>

	<p>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 [fillable field] (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.</p> <p>2. Applicant or Applicant's Authorized Representative's Signature Date of Signature (mm/dd/yyyy)</p>	<p>for naturalization. I certify under penalty of perjury, pursuant to 28 U.S.C. section 1746, that the information I provided to the certifying 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 [fillable field] (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 medical disability exception.</p> <p>2. Applicant Signature (or mark if applicant is unable to sign) Date of Signature (mm/dd/yyyy)</p>
<p>Page 8-9, Part 6. Medical Professional's Certification</p>	<p>[Page 8]</p> <p>Part 6. Medical Professional's Certification</p> <p>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.</p> <p>1. I did not use an interpreter during my examinations of this applicant because: I am fluent in English and [fillable field], the language spoken by this applicant This applicant speaks English.</p> <p>[Page 9]</p> <p>All medical professionals must complete the certification below.</p> <p>[new]</p> <p>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):</p>	<p>[Page 5]</p> <p>Part 7. Medical Professional's Certification</p> <p>[deleted]</p> <p>I certify that:</p> <p>1. I have examined the applicant/patient listed in Part 1. above.</p> <p>2. I will furnish relevant medical records to USCIS, if requested to do so by USCIS, based on the applicant's consent in Part 6.</p> <p>3. 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):</p>

	<p>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.</p> <p>3. Licensed Medical Professional Signature Date of Signature (mm/dd/yyyy)</p>	<p>Additionally, 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 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.</p> <p>4. Certifying Medical Professional Signature Date of Signature (mm/dd/yyyy)</p>
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