Application for Civil Surgeon Designation

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

USCIS
Form I-910
OMB No. 1615-0114
Expires 11/30/2025

For USCIS Use Only	Initial Receipt	Barcode	Action Block
	Resubmitted		
Received	Remarks		
Sent			
	CSID Number		

To be completed by an attorney or accredited representative (if any).	☐ Select this box if Form G-28 is attached.	Attorney State Bar Number (if applicable)	Attorney or Accredited Representative USCIS Online Account Number (if any)

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

Part 1. Information About You (The Applicant)

1. Have you ever been designated as a civil surgeon? ☐ Yes ☐ No

If you answered "Yes" to **Item Number 1.**, provide the following information.

2. Civil Surgeon Identification Number (CSID) (if known)

3. Period of Designation (mm/dd/yyyy) From To

4. Has USCIS ever revoked your designation? ☐ Yes ☐ No

If you answered "Yes" to **Item Number 4.**, provide the following information.

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

6. Have you ever voluntarily terminated your designation? ☐ Yes ☐ No

If you answered "Yes" to **Item Number 6.**, provide the following information.

7. Date of Voluntary Termination (mm/dd/yyyy)

NOTE: If you answered "Yes" to **Item Number 4.** or **Item Number 6.**, include a typed or printed explanation of the circumstances surrounding the revocation or voluntary termination in **Part 10. Additional Information**.

8. Your Full Legal Name (Do not provide a nickname)

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

Part 1. Information About You (The Applicant) (continued)

Other Information

9. Other Names Used (if any)

Provide all other names you have ever used, including aliases, maiden name, and nicknames. If you need extra space to complete this section, use the space provided in **Part 10. Additional Information**.

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

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

11. Gender ☐ Male ☐ Female

12. USCIS Online Account Number (if any)

►

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

► **A-**

Part 2. Clinical Office Locations

Provide the following information about the locations where you seek to perform immigration medical examinations. If you seek to perform immigration medical examinations in more than one location, provide the details for each additional location in the space provided in **Part 10. Additional Information**.

You must provide the following information. Failure to provide this information may result in the denial of your application. USCIS displays information regarding a clinic/practice location and contact information on our website for people who want to find a civil surgeon. USCIS will use the contact information listed below for all civil surgeon-related communications.

1. Name of Clinic/Practice

2. Physical Address of the Clinic/Practice *(USPS ZIP Code Lookup)*

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

City or Town | State | ZIP Code

3. County of Practice

4. Telephone Number **5.** Fax Number (if any) **6.** Email Address

7. Website Address (URL) (if any) **8.** Additional Languages Spoken (if any)

9. Physician Email Address (for USCIS use)

10. Is the clinic's physical address the same as the clinic's mailing address? ☐ Yes ☐ No

If you answered "No" to **Item Number 10.**, provide the clinic's mailing address in **Item Number 11.**

Part 2. Clinical Office Locations (continued)

11. Mailing Address of the Clinic/Practice

In Care Of Name (if any)

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

City or Town | State | ZIP Code

Part 3. Information About Your Status in the United States

You must be authorized to work in the United States to be eligible for civil surgeon designation. Select the box that accurately states how you are authorized to work in the United States. (Select **only one** box.)

1. ☐ I am a U.S. citizen or national.
(Attach proof that you are a U.S. citizen or national, such as a copy of an unexpired U.S. passport, birth certificate, or Certificate of Naturalization.)

2. ☐ I am a lawful permanent resident. (Attach a copy of your valid Form I-551, Permanent Resident Card. If you are currently seeking to renew or replace your Form I-551, attach evidence showing that you are doing so.)

3. A. ☐ I am currently present in the United States as a nonimmigrant. Provide the information requested in **Items B. - H.** in **Item Number 3.** (Attach a copy of your Form I-94 Arrival-Departure Record, a copy of your passport or travel document, and any documents related to your nonimmigrant status, such as a copy of the petition, petition approval, and change or extension of status application. Also attach a copy of your valid, unexpired Employment Authorization Document as proof of your authorization to work in the United States, if required.)

B. Date of Last Arrival in the U.S. (mm/dd/yyyy)

C. Form I-94 Arrival-Departure Record Number (if any) ▶

D. Passport or Travel Document Number

E. Country of Issuance for Passport or Travel Document

F. Expiration Date for Passport or Travel Document (mm/dd/yyyy)

G. Current Nonimmigrant Status

H. I have an Employment Authorization Document (EAD) granted by USCIS that authorizes me to work in the United States. (Attach a copy of your valid, unexpired EAD as proof of your authorization to work in the United States.) ☐ Yes ☐ No

Part 4. Medical Degrees

You must possess a medical degree as a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) to be eligible for civil surgeon designation. **Attach a copy of your medical degree** and complete the chart below.

Name of School	**Dates of Attendance** (mm/dd/yyyy) **From**	**To**	**Graduation Date** (mm/dd/yyyy)	**Degree**

Part 5. Medical Licenses

You must have an active and unrestricted license to practice medicine in the state or U.S. territory where you seek to perform immigration medical examinations to be eligible for civil surgeon designation. **Attach a copy of each medical license listed below.** If you need extra space to complete this section, use the space provided in **Part 10. Additional Information**.

State or U.S. Territory	Medical License Number	Date Issue (mm/dd/yyyy)	Date Expires (mm/dd/yyyy)	Good Standing? (Y/N)
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

If your medical license is restricted, temporary, or not in good standing; include any relevant documentation and a typed or printed explanation of the circumstances in **Part 10. Additional Information**.

Part 6. Professional Experience

You must establish that you have practiced medicine as a physician (M.D. or D.O.) in the U.S. for at least four years to be eligible for designation.

NOTE: In calculating whether you meet the requirement of four years of practice as a physician, do **NOT** count your post graduate medical training in an internship or residency program. You can, however, count the time you practiced medicine on the basis of a post-residency fellowship.

Submit evidence to establish your professional experience, such as letters of employment verification, evaluations, certificates of completion, business tax returns and the business license covering tax returns period (for self-employed physicians), or medical liability or malpractice insurance policy. A medical liability/malpractice insurance policy, by itself, is insufficient to establish professional experience, but may be submitted to supplement other evidence listed above. If you need extra space to complete this section, use the space provided in **Part 10. Additional Information**.

Employer 1

1. Employer's Name

Dates of Employment (mm/dd/yyyy)
From To

Employer's Daytime Telephone Number

Employer's Address
Street Number and Name

Apt. Ste. Flr. Number

City or Town

State

ZIP Code

Part 6. Professional Experience (continued)

Employer 2

2. Employer's Name

Dates of Employment (mm/dd/yyyy)

From To

Employer's Daytime Telephone Number

Employer's Address

Street Number and Name

Apt. Ste. Flr. Number

City or Town

State

ZIP Code

Part 7. Applicant's Statement, Contact Information, Certification, and Signature

NOTE: Read the **Penalties** section of the Form I-910 Instructions before completing this section. You must file Form I-910 while in the United States.

Applicant's Statement

NOTE: Select the box for either **Item A.** or **B.** in **Item Number 1.** If applicable, select the box for **Item Number 2.**

1. Applicant's Statement Regarding the Interpreter

A. ☐ I can read and understand English, and I have read and understand every question and instruction on this application and my answer to every question.

B. ☐ The interpreter named in **Part 8.** read to me every question and instruction on this application and my answer to every question, in , a language in which I am fluent, and I understand everything.

2. Applicant's Statement Regarding the Preparer

☐ At my request, the preparer named in **Part 9.**, , prepared this application for me based only upon information I provided or authorized.

Applicant's Contact Information

3. Applicant's Daytime Telephone Number

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

5. Applicant's Email Address (if any)

Part 7. Applicant's Statement, Contact Information, Certification, and Signature (continued)

Applicant's Certification

By signing this application, I accept civil surgeon designation if my request for designation is granted. Once designated as a civil surgeon, I agree that I will perform the medical examinations according to the regulations published by Health and Human Services (HHS) at 42 CFR Part 34 and the "Technical Instructions for Civil Surgeons" published by the Centers for Disease Control and Prevention (CDC).

By signing this application, I further agree to comply fully with the regulations at 8 CFR Part 232. I understand that USCIS reserves the right to revoke civil surgeon designation in certain circumstances.

Copies of any documents I have submitted are exact photocopies of unaltered, original documents, and I understand that USCIS may require that I submit original documents to USCIS at a later date. Furthermore, I authorize the release of any information from any and all of my records that USCIS may need to determine my eligibility for designation as a civil surgeon.

I furthermore authorize release of information contained in this application, in supporting documents, and in my USCIS records, to other entities and persons where necessary for the administration and enforcement of U.S. immigration law.

I certify, under penalty of perjury, that I provided or authorized all of the information in my application, I understand all of the information contained in, and submitted with, my application, and that all of this information is complete, true, and correct.

Applicant's Signature

6. Applicant's Signature | Date of Signature (mm/dd/yyyy)

Your signature will be kept on record to verify the signature on any submitted Form I-693.

NOTE TO ALL APPLICANTS: If you do not completely fill out this application or fail to submit required documents listed in the Instructions, USCIS may deny your application.

Part 8. Interpreter's Contact Information, Certification, and Signature

Provide the following information about the interpreter.

Interpreter's Full Name

1. Interpreter's Family Name (Last Name) | Interpreter's Given Name (First Name)

2. Interpreter's Business or Organization Name (if any)

Interpreter's Mailing Address

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

City or Town | State | ZIP Code

Province | Postal Code | Country

Part 8. Interpreter's Contact Information, Certification, and Signature (continued)

Interpreter's Contact Information

4. Interpreter's Daytime Telephone Number

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

6. Interpreter's Email Address (if any)

Interpreter's Certification

I certify, under penalty of perjury, that:

I am fluent in English and _____ which is the same language specified in **Part 7.**, **Item B.** in **Item Number 1.**, and I have read to this applicant in the identified language every question and instruction on this application and his or her answer to every question. The applicant informed me that he or she understands every instruction, question, and answer on the application, including the **Applicant's Certification**, and has verified the accuracy of every answer.

Interpreter's Signature

7. Interpreter's Signature

Date of Signature (mm/dd/yyyy)

Part 9. Contact Information, Declaration, and Signature of the Person Preparing this Application, if Other Than the Applicant

Provide the following information about the preparer.

Preparer's Full Name

1. Preparer's Family Name (Last Name)

Preparer's Given Name (First Name)

2. Preparer's Business or Organization Name (if any)

Preparer's Mailing Address

3. Street Number and Name

Apt. Ste. Flr. Number

City or Town

State

ZIP Code

Province

Postal Code

Country

Part 9. Contact Information, Declaration, and Signature of the Person Preparing this Application, if Other Than the Applicant (continued)

Preparer's Contact Information

4. Preparer's Daytime Telephone Number

5. Preparer's Mobile Telephone Number (if any)

6. Preparer's Email Address (if any)

7. ☐ Select this box if the preparer may act as a secondary point of contact for you. USCIS will contact this preparer if you cannot be reached using the information in **Part 2.**

Preparer's Statement

8. A. ☐ I am not an attorney or accredited representative but have prepared this application on behalf of the applicant and with the applicant's consent.

B. ☐ I am an attorney or accredited representative and my representation of the applicant in this case ☐ extends ☐ does not extend beyond the preparation of this application.

NOTE: If you are an attorney or accredited representative, you may need to submit a completed Form G-28, Notice of Entry of Appearance as Attorney or Accredited Representative, with this application.

Preparer's Certification

By my signature, I certify, under penalty of perjury, that I prepared this application at the request of the applicant. The applicant then reviewed this completed application and informed me that he or she understands all of the information contained in, and submitted with, his or her application, including the **Applicant's Certification**, and that all of this information is complete, true, and correct. I completed this application based only on information that the applicant provided to me or authorized me to obtain or use.

Preparer's Signature

9. Preparer's Signature

Date of Signature (mm/dd/yyyy)

Part 10. Additional Information

If you need extra space to provide any additional information within this application, use the space below. If you need more space than what is provided, you may make copies of this page to complete and file with this application or attach a separate sheet of paper. Type or print your name and CSID Number (if any) at the top of each sheet; indicate the **Page Number**, **Part Number**, and **Item Number** to which your answer refers; and sign and date each sheet.

1. Family Name (Last Name) | Given Name (First Name) | Middle Name

2. CSID Number (if any)

3. **A.** Page Number **B.** Part Number **C.** Item Number

D.

4. **A.** Page Number **B.** Part Number **C.** Item Number

D.

5. **A.** Page Number **B.** Part Number **C.** Item Number

D.

6. **A.** Page Number **B.** Part Number **C.** Item Number

D.

7. **A.** Page Number **B.** Part Number **C.** Item Number

D.