OMB No. 1615-0033

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

Form I-693, Report of Medical Examination and Vaccination Record

START HERE - Type or print in CAPITAL letters (*Use black ink*)

Part 1. Information About You *(To be completed by the person requesting a medical examination, not the civil surgeon)*

Family Name (Last Name) | Given Name (First Name) | Full Middle Name

Home Address: Street Number and Name | Apt. Number | Gender: ☐ Male ☐ Female

City | State | Zip Code | Phone # *(Include Area Code) no dashes or ()*

Date of Birth *(mm/dd/yyyy)* | Place of Birth *(City/Town/Village)* | Country of Birth | A-Number *(if any)* | U.S. Social Security # *(if any)*

Applicant's Certification

I certify under penalty of perjury under United States law that I am the person who is identified in **Part 1** of this Form I-693, Report of Medical Examination and Vaccination Record, and that the information in **Part 1** of this form is true to the best of my knowledge. I understand the purpose of this medical exam, and I authorize the required tests and procedures to be completed. If it is determined that I willfully misrepresented a material fact or provided false/altered information or documents with regard to my medical exam, I understand that any immigration benefit I derived from this medical exam may be revoked, that I may be removed from the United States, and that I may be subject to civil or criminal penalties.

Signature - Do not sign or date this form until instructed to do so by the civil surgeon | **Date** *(mm/dd/yyyy)*

To be completed by civil surgeon: Form of applicant ID presented *(e.g., passport, driver's license)* | **ID Number** *(if any)*

Part 2. Summary of Medical Examination *(To be completed by the civil surgeon)*

Summary of Overall Findings:

☐ No Class A or Class B Condition

☐ Class A Conditions *(see Civil Surgeon Worksheet, sections 1-3)*

☐ Class B Conditions *(see Civil Surgeon Worksheet, sections 1-4)*

Date of First Examination *(mm/dd/yyyy)*

Date(s) of Follow-up Examination(s) if Required:

Date of Exam *(mm/dd/yyyy)* | **Date of Exam** *(mm/dd/yyyy)* | **Date of Exam** *(mm/dd/yyyy)*

Part 3. Civil Surgeon's Certification *(Do not sign form or have the applicant sign in Part 1 until all health follow-up requirements have been met)*

I certify under penalty of perjury under United States law that: I am a civil surgeon designated to examine applicants seeking certain immigration benefits in the U.S. OR a physician who qualifies under a blanket designation specified by policy or law; I have a currently valid and unrestricted license to practice medicine in the state where I am performing medical examinations unless exempted from this requirement; I performed this examination of the person identified in Part 1 of this Form I-693, after having made every reasonable effort to verify that the person whom I examined is in fact the person identified in Part 1; that I performed the examination in accordance with the Centers for Disease Control and Prevention's Technical Instructions, and all supplemental information or updates; and that all information provided by me on this form is true and correct to the best of my knowledge, and belief.

Type or Print Full Name *(First, Middle, Last)*

(For Health Departments Only: Place official stamp or seal here)

Address *(Street Number and Name, City, State, and Zip Code)*

Name of Medical Practice or Health Department | **Signature**

E-Mail/Daytime Phone # *(Include Area Code) no dashes or ( )* | **Date** *(mm/dd/yyyy)*

Name of Applicant *(Last, First, Middle)*

A-Number *(if any)*

CIVIL SURGEON WORKSHEET

(To be completed by the civil surgeon, according to the Technical Instructions *at http://www.cdc.gov/immigrantrefugeehealth/exams/ti/civil/technical-instructions-civil-surgeons.html)*

1. Communicable Diseases of Public Health Significance

A. Tuberculosis (TB): An initial screening test, either a Tuberculin Skin Test (TST) or an Interferon Gamma Release Assay (IGRA) is required for all applicants 2 years of age and older; for children under 2 years of age, see *Technical Instructions*. The civil surgeon should perform **one type of initial screening test only**, followed by further evaluation, if needed (chest X-ray).

1. Tuberculin Skin Test (TST):

☐ Not administered *(TST exception applies; please explain in Remarks section below)*

Date TST Applied *(mm/dd/yyyy)* | Date TST Read *(mm/dd/yyyy)* | Size of Reaction *(mm)*

Result: ☐ Negative *(4mm or less of induration)* ☐ Positive *(≥ 5mm; chest X-ray required)*

2. Interferon Gamma Release Assay (IGRA) *(for acceptable IGRAs consult the* Technical Instructions *and any updates posted on CDC's Web site)*:

☐ Not administered *(IGRA exception applies; please explain in Remarks section below)*

Name of Test | Date Blood Sample Drawn *(mm/dd/yyyy)* | IU/ml:

Result: ☐ Negative (including indeterminate, or borderline/equivocal) *(no chest X-ray required)*
☐ Positive *(chest X-ray required)*

3. Initial Screening Test Result and Chest X-Ray Determination:

☐ Chest X-ray not required *(medically cleared for TB for USCIS)*
☐ Chest X-ray required due to initial screening test results
☐ Chest X-ray required due to TB signs or symptoms, or due to immunosuppression *(e.g. HIV)*
☐ Chest X-ray required due to TST or IGRA exception *(The civil surgeon must clearly specify the TST or IGRA exception in the Remarks section below)*

4. Chest X-Ray: Required based on TST or IGRA result, or if specific TST or IGRA exceptions apply, or for an applicant with TB signs or symptoms or immunosuppression (e.g., HIV). **Attach a copy of X-ray report.**

Date Chest X-Ray Taken *(mm/dd/yyyy)* | **Date Chest X-Ray Read** *(mm/dd/yyyy)*

Result: ☐ Normal ☐ Abnormal *(describe results in remarks)*

TB Classification/Findings (check only if chest x-ray was performed):

☐ No Class A or Class B TB
☐ Class A Pulmonary TB Disease
☐ Class B1 Pulmonary TB
☐ Class B1 Extra Pulmonary TB
☐ Class B2 Pulmonary TB
☐ Class B, Latent TB Infection
☐ Class B, Other Chest Condition (non-TB)

Remarks: *(If needed, include any signs or symptoms of TB, additional tests and therapy given, with start and stop dates and any changes. If tests were not administered, give reason why exception applies)*

Name of Applicant *(Last, First, Middle)*

A-Number *(if any)*

CIVIL SURGEON WORKSHEET *(Continued)*

B. Syphilis

☐ Serologic Test for Syphilis *(Required for applicants 15 years and older)*

Date Screening Run *(mm/dd/yyyy)*

If Reactive, Date Confirmation Run *(mm/dd/yyyy)*

☐ Screening Nonreactive

☐ Screening Reactive, Titer 1: _____

☐ Confirmation Nonreactive

☐ Confirmation Reactive

Findings:

☐ No Class A or Class B Syphilis ☐ Syphilis, Class A *(untreated)* ☐ Syphilis, Class B *(with residual deficit, and treated in the past year)*

Remarks: *(Include any therapy given with doses and dates)*

C. Other Class A/Class B Conditions for Communicable Diseases of Public Health Significance

Findings:

☐ No Class A/B Condition ☐ Gonorrhea, Class A ☐ Hansen's Disease *(Leprosy, Noninfectious)*, Class B

☐ Chancroid, Class A ☐ Lymphogranuloma Venereum, Class A

☐ Granuloma Inguinale, Class A ☐ Hansen's Disease *(Leprosy, Infectious)*, Class A

Remarks: *(Include any therapy given and any counseling or referrals)*

2. Physical or Mental Disorders With Associated Harmful Behavior

* (Include here any diagnosis of substance abuse/addiction based on DSM criteria for a substance that is not listed in Schedule I, II, III, IV, or V under Section 202 of the Controlled Substance Act with current associated harmful behavior or history of associated harmful behavior judged likely to recur. This category includes diagnosis of alcohol abuse/dependence.)

☐ No Class A or B Physical or Mental Disorder*

☐ Current Physical/Mental Disorder with Associated Harmful Behavior,* Class A

☐ History of Physical/Mental Disorder with Associated Harmful Behavior Likely to Recur, Class A*

☐ Current Physical/Mental Disorder without Associated Harmful Behavior,* Class B

☐ History of Physical/Mental Disorder with Associated Harmful Behavior Unlikely to Recur,* Class B

Remarks: *(Include diagnosis, likelihood of recurrence of the harmful behavior, therapy given, and any counseling, or referrals. Attach a separate sheet of paper (with applicant's name and A#) if more space is necessary)*

3. Drug Abuse/Drug Addiction

** ("Drug Abuse/Drug Addiction" addresses non-medical use **only** with respect to substances listed in Schedule I, II, III, IV, or V under Section 202 of the Controlled Substances Act. Include here any diagnosis of substance abuse/dependence based on DSM criteria for a substance listed in Schedule I, II, III, IV, or V of section 202 of the Controlled Substances Act. See CDC's Technical Instructions for more information.)

☐ No Class A or B Substance (Drug) Abuse/Addiction**

☐ Substance (Drug) Abuse/Addiction, Listed in Section 202 of the Controlled Substances Act,** Class A

☐ Substance (Drug) Abuse/Addiction in Full Remission, Listed in Section 202 of the Controlled Substances Act,** Class B

Name of Applicant *(Last, First, Middle)*

A-Number *(if any)*

CIVIL SURGEON WORKSHEET *(Continued)*

3. Drug Abuse/Drug Addiction *(Continued)*

Remarks: *(Include any therapy given, rehabilitation, counseling, or referrals. Attach a separate sheet of paper (with applicant's name and A#) if more space is necessary)*

4. Other Medical Conditions *(List any other Class B conditions, e.g., hypertension, diabetes)*

5. Referral to Health Department or Other Doctor/Facility *(To be completed by civil surgeon, if referral was medically required)*

Type or Print Name of Doctor or Health Department Receiving Required Referral

Address *(Street Number and Name, City, State, and Zip Code)*

Date of Referral *(mm/dd/yyyy)*

Remarks: *(Include name of medical condition and reasons for referral)*

6. Referral Evaluation *(To be completed by the health department or other doctor performing the referral evaluation)*

The applicant identified on this form was referred to me by the civil surgeon named in **Part 3** of this form. I have provided appropriate evaluation/treatment, having made every reasonable effort to verify that the person whom I evaluated/treated is the person identified in **Part 1**.

Type or Print Full Name of Evaluating Physician or Health Department

Signature

Address *(Street Number and Name, City, State, and Zip Code)*

Date *(mm/dd/yyyy)*

Name of Medical Practice or Health Department

Daytime Phone # *(Include Area Code) no dashes or ( )*

Remarks: *(Attach a separate sheet of paper, if needed)*

Name of Applicant *(Last, First, Middle)*

A-Number *(if any)*

VACCINATION RECORD

(See Technical Instructions *at http://www.cdc.gov/immigrantrefugeehealth/exams/ti/civil/vaccination-civil-technical-instructions.html for list of required vaccines)*

Please make sure every row is marked. Reserve all comments for the Remarks section below. **Note:** For purposes of the influenza vaccine, the flu season is October 1 through March 31. **For certain applicants who only require a vaccination assessment:** You need only submit this page with Page 1 of Form I-693. See Form Instructions - FAQ section for more information.

Vaccine History Transferred From a Written Record				Vaccine Given	Completed Series	Waiver(s) to Be Requested From USCIS			
Vaccine	Date Recieved *mm/dd/yy*	Date Received *mm/dd/yy*	Date Received *mm/dd/yy*	Date Given by Civil Surgeon *mm/dd/yy*	Mark an X if complete; write date of lab test if immune or "VH" if varicella history	Blanket			
						Not Medically Appropriate			
						Not Age Appropriate	Contra-indication	Insufficient Time Interval	Not Flu Season
Specify ☐ DT Vaccine: ☐ DTP ☐ DTaP									
Specify ☐ Td Vaccine: ☐ Tdap									
Specify ☐ OPV Vaccine: ☐ IPV									
MMR (Measles Mumps-Rubella) or if monovalent or other combination of the vaccines are given, specify vaccine(s):									
Hib									
Hepatitis B									
Varicella									
Pneumococcal									
Influenza									
Rotavirus									
Hepatitis A									
Menigococcal									

Give a Copy to Applicant

FOR USCIS USE ONLY

Results:
- ☐ Applicant may be eligible for blanket waiver(s) as indicated above
- ☐ Applicant will request an individual waiver based on religious or moral convictions
- ☐ Vaccine history complete for each vaccine, all requirements met
- ☐ Applicant does not meet immunization requirements

Remarks: *(If needed, provide any remarks: e.g., reason for contraindication)*

Remarks *(if any)***:**