

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	
<input type="text"/>		<input type="text"/>		<input type="text"/>	
Home Address: Street Number and Name				Apt. Number	Gender:
<input type="text"/>				<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female
City	State	Zip Code		Phone # (Include Area Code) no dashes or ()	
<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>	
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)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	

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)
<input type="text"/>	<input type="text"/>
To be completed by civil surgeon: Form of applicant ID presented (e.g., passport, driver's license)	ID Number (if any)
<input type="text"/>	<input type="text"/>

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:		
<input type="text"/>	Date of Exam (mm/dd/yyyy)	Date of Exam (mm/dd/yyyy)	Date of Exam (mm/dd/yyyy)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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 otherwise exempted; 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)

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

Name of Medical Practice or Health Department

E-Mail/Daytime Phone # (Include Area Code)

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

Signature

Date (mm/dd/yyyy)

Family Name (Last Name)

Given Name (First Name)

Full Middle Name

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 (≥ 5 mm; 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 B1 Extra Pulmonary TB

Class B, Other Chest

Class A Pulmonary TB Disease

Class B2 Pulmonary TB

Condition (non-TB)

Class B1 Pulmonary TB

Class B, Latent TB Infection

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).

Family Name (Last Name)

Given Name (First Name)

Full Middle Name

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)

Screening Nonreactive

Screening Reactive, Titer 1: _____

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

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

Family Name (Last Name)

Given Name (First Name)

Full Middle Name

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 (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)

Family Name (Last Name)	Given Name (First Name)	Full Middle Name	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 Received <i>mm/dd/yy</i>	Date Received <i>mm/dd/yy</i>	Date Received <i>mm/dd/yy</i>	Date Given by Civil Surgeon <i>mm/dd/yy</i>	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 <input type="checkbox"/> Vaccine: DTP <input type="checkbox"/> DTaP <input type="checkbox"/>									
Specify Td <input type="checkbox"/> Vaccine: Tdap <input type="checkbox"/>									
Specify OPV <input type="checkbox"/> Vaccine: IPV <input type="checkbox"/>									
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									
Meningococcal									

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):