

COMPLETING FORM I-693, REPORT OF MEDICAL EXAMINATION AND VACCINATION RECORD

by Yeu S. Hong and Paul L. Samartin*

NOTE: Always check the website for the most recent version of this form and current filing fees!

[Form I-693, Report of Medical Examination and Vaccination Record](#), is used by U.S. Citizenship and Immigration Services (USCIS) to establish whether an applicant for adjustment of status is inadmissible to the United States on public health grounds. A list of health grounds of inadmissibility may be found at Immigration and Nationality Act (INA) §212(a)(1).

Except for Part 1, the Form I-693 is completed by a USCIS designated physician (also known as a civil surgeon). To find a USCIS designated civil surgeon, the applicant may call the USCIS National Customer Service Center at (800) 375-5283 and follow the automated menu or go to www.uscis.com and click on “Find a Medical Doctor (Civil Surgeon)” under the “I Want To” customer tool sidebar.

The results of the medical examination are confidential and are used only for immigration purposes. When required by law, the civil surgeon may share the applicant’s results with public health authorities.

The civil surgeon will ask the applicant to verify identity through a valid government issued photo identification such as a valid unexpired passport or driver’s license. For applicants under 14, the USCIS will accept other proof of identity that shows the applicant’s name, date and place of birth, parents’ full names, and any other identifying information about the applicant. Acceptable documents include birth certificates or affidavits. In addition, the applicant should bring any vaccination records to the appointment to minimize the need for, and cost of administering or re-administering, vaccinations during the medical examination.

PART 1 – INFORMATION ABOUT YOU

This section is designed to gather general biographical information about the applicant requesting the medical examination and to certify under penalty of perjury that the applicant identified in this section and information provided is true to the best of the applicant’s knowledge. In addition, the applicant is verifying that he or she understands the purpose of the medical examination and authorizes the civil surgeon to perform the required tests and procedures as required under the law and guidance. This section is the only part of Form I-693 that is completed by the applicant requesting the medical examination. The civil surgeon will instruct the applicant to sign and date the “Applicant’s Confirmation” in this section. The applicant should use black ink only and write “N/A” if a question does not apply unless the instructions indicate otherwise.

A. Name

The applicant should insert his or her legal name. If the applicant has two last names, he or she must include both names using a hyphen if appropriate.

Articles do not necessarily reflect the views of the American Immigration Lawyers Association.

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Paul L. Samartin is head of the U.S. immigration practice at Laura Devine Solicitors. Mr. Samartin specializes in business- and family-based immigration to the United States and has extensive experience working with embassies and consulates throughout Europe. He regularly speaks on a wide range of business- and family-based immigration matters, and has written numerous articles for AILA. He earned his J.D. from Pepperdine University School of Law and is admitted to the State Bar of California.

B. Home Address

The applicant should insert the physical street address. Do not use a post office box number.

C. Date of Birth

Use eight numbers to show the date of birth. For example May 22, 1972, must be written 05/22/1972.

D. Place of Birth

Give the name of the city/town/village where applicant was born.

E. Country of Birth

Give the name of the country where applicant was born.

F. A-Number

This is the applicant's alien registration number. The A-Number is typically located on relevant USCIS receipt notices in the "USCIS Alien Number" section and contains an "A" followed by a nine digit number, such as A123456789. If the applicant does not have an A-Number, the applicant should leave this space blank.

G. U.S. Social Security Number

If the applicant does not have a Social Security number, leave this space blank.

H. Applicant's Certification

The applicant should not sign the form until the civil surgeon instructs him or her to do so during the medical examination.

I. Identifying Information of Top of Each Page After Page 1

Applicant should fill out name and A-number, if applicable, at the top of each page of Form I-693. The civil surgeon will check to make sure this information matches Part 1.

PART 2 – SUMMARY OF MEDICAL EXAMINATION

This section provides a summary of the medical examination. It includes information related to the date of examination and any follow-up examinations as well as a section to indicate a summary of overall findings. The civil surgeon will check off the box indicating no Class A or B condition or check off the box indicating either a Class A or Class B condition exists.

PART 3 – CIVIL SURGEON CERTIFICATION

This section is designed to gather general information from the civil surgeon. In addition, the civil surgeon will sign this section to certify under penalty of perjury that he or she qualifies as a USCIS designated civil surgeon, verified the identity of the applicant, and completed the medical examination in accordance with the Centers of Disease Control (CDC) and Prevention's Technical Instructions. If the civil surgeon has referred the applicant for further tests or an evaluation, he or she will not sign and date until the further tests and/or follow-up evaluation (if required) have been completed and the applicant has been medically cleared.

CIVIL SURGEON WORKSHEET

The civil surgeon worksheet section relates to specific health conditions enumerated in INA §212(a)(1) which are a part of the medical examination.

1. Communicable Diseases of Public Health Significance

- Tuberculosis – Either a Tuberculin Skin Test or Interferon Gamma Release Array is required for applicants two years of age or older. The civil surgeon should perform only one type of the initial screening test, followed by further evaluation, if necessary.

- Syphilis – Applicants 15 years old and older must have blood tests for Syphilis. In addition, children under the age of 15 may be required to be tested if the civil surgeon has reason to believe the applicant is infected with Syphilis.
- Other Class A/Class B Conditions for Communicable Diseases of Public Health Significance – These conditions include Leprosy (Hansen’s Disease), Gonorrhea, Lymphogranuloma Venereum, Chancroid and Granuloma Inguinale.

2. Physical or Mental Disorders With Associated Harmful Behavior

The civil surgeon will include any diagnosis of substance abuse/addiction based on DSM criteria for a substance not listed on 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.

3. Drug Abuse/Drug Addiction

This addresses non-medical use only with respect to substances listed on Schedule I, II, III, IV, or V under Section 202 of the Controlled Substance Act. The civil surgeon will include any diagnosis of substance abuse/addiction based on DSM criteria for a substance not listed on Schedule I, II, III, IV, or V under Section 202 of the Controlled Substance Act.

4. Other Medical Conditions

The civil surgeon will list other Class B conditions, *e.g.*, hypertension, diabetes.

5. Referral to Health Department or Other Doctor

The civil surgeon will complete this section and refer the applicant to the appropriate local health department or refer the applicant to complete treatment if he or she tests positive for certain diseases in accordance with the CDC’s Technical Instructions.

6. Referral Evaluation

The health care professional receiving a referral from the civil surgeon must fill out and sign section 6 following completion of treatment.

VACCINATION RECORD

This section provides the civil surgeon the opportunity to complete the vaccination worksheet and provide the results of the vaccination record review. All applicants for adjustment of status must present documents showing that he or she has been vaccinated against a broad range of vaccine-preventable diseases. The civil surgeon will review the applicant’s vaccination history and determine if the applicant has all of the required vaccinations. Applicants should not attempt to meet the requirements before being evaluated by the civil surgeon in case it is not medically appropriate for the applicant to have one or more of the required vaccinations. The civil surgeon may certify that one or more of the vaccinations are not medically appropriate for the applicant. If the applicant cannot prove he or she received the required vaccinations, or has never received a required vaccination, the civil surgeon will administer the vaccination.

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



Report of Medical Examination and Vaccination Record

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

USCIS
Form I-693
OMB No. 1615-0033
Expires 01/31/2015

► **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
TERWILLIGER	Shane	Sidney
Home Address: Street Number and Name		Apt. Number
200 West 83rd Street		5D
City		State
New York		New York
Zip Code		Phone Number
10024		(555) 555 - 5555
Date of Birth (mm/dd/yyyy)	Place of Birth (City/Town/Village)	Country of Birth
10/20/1979	Melbourne	Australia
A-Number (if any)		
A-		

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/alter 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 of Signature (mm/dd/yyyy)

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

ID Number

Australian Passport	0788504556
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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 B Conditions (see Civil Surgeon Worksheet, sections 1-4) ☐ Class A Conditions (see Civil Surgeon Worksheet, sections 1-3)

Date of First Examination (mm/dd/yyyy)	Date(s) of Follow-up Examination(s) below if required:		
02/14/2013	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 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)

Dr Michael Robert Gunns

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

222 Central Park West

Name of Medical Practice, Facility, or Health Department

New York Medical Clinic

(Health Departments **MUST**
place their official stamp or seal here)

Signature

Daytime Phone Number

(555) 555 - 5557

E-Mail

mrgunns@nymc.com

Date Signed (mm/dd/yyyy)

Family Name (Last Name)	Given Name (First Name)	Full Middle Name	A-Number (if any)
TERWILLIGER	Shane	Sidney	

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)

02/14/2013

Date TST Read (mm/dd/yyyy)

02/16/2013

Size of Reaction (mm)

0MM

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).

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)
TERWILLIGER	Shane	Sidney	

CIVIL SURGEON WORKSHEET (Continued)

B. Syphilis

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

Date Screening Run (mm/dd/yyyy)

02/14/2013

☒ 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 B (with or without residual deficit and treated in the past year)

☐ Syphilis, Class A (untreated)

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

☐ Hansen's Disease (Leprosy, any classification) untreated, Class A

☐ Chancroid, Class A

☐ Indeterminate, tuberculoid, borderline tuberculoid (paucibacillary)

☐ Granuloma Inguinale, Class A

☐ Mid-borderline, borderline lepromatous, lepromatous (multibacillary)

☐ Gonorrhea, Class A

☐ Hansen's Disease (Leprosy, any classification) treated or partially treated, Class B

☐ Lymphogranuloma Venereum, Class A

☐ Indeterminate, tuberculoid, borderline tuberculoid (paucibacillary)

☐ Mid-borderline, borderline lepromatous, lepromatous (multibacillary)

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-Number) 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)
TERWILLIGER	Shane	Sidney	

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-Number) if more space is necessary)

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

None

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

N/A

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

N/A

Signature

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

Date Signed (mm/dd/yyyy)

Name of Medical Practice or Health Department

Daytime Phone Number

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

Family Name (Last Name)	Given Name (First Name)	Full Middle Name	A-Number (if any)
TERWILLIGER	Shane	Sidney	

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 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	☒			02/14/13	☒	☐	☐	☐	
Specify OPV Vaccine: IPV	☐				☐	☒	☐	☐	
MMR (Measles Mumps-Rubella) or if monovalent or other combination of the vaccines are given, specify vaccine(s):				02/14/13	☒	☐	☐	☐	
Hib					☐	☒	☐	☐	
Hepatitis B					☐	☒	☐	☐	
Varicella				02/14/13	☒	☐	☐	☐	
Pneumococcal					☐	☒	☐	☐	
Influenza				02/14/13	☒	☐	☐	☐	
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)

N/A

Remarks (if any):