Supplement 1,
Applicants With a Class A Tuberculosis Condition
(As Defined by Health and Human Services Regulations)

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

USCIS
Form I-690
OMB No. 1615-0032
Expires 11/30/2014

Applicant's Name and Alien Registration Number (A-Number) (if any) ► **A-**

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

Section A. Applicant's Sponsor in the United States

1. Make arrangements for the applicant's medical care and have the attending physician or facility complete **Section C.**
2. Obtain the necessary endorsements.
   - **A. Treatment is being provided by a local health department**. If a local health department will provide the necessary care and/or treatment to the applicant, that facility should select block **(A.)** in **Item Number 4.** under **Section C.**
   - **B. Treatment is being provided by a private physician or by any other private or public facility:** If a private physician, a private medical facility or a public medical facility (other than a local health department) will provide the applicant's medical care and/or treatment, that facility should select block **(B.)** or **(C.)** in **Item Number 4**. of **Section C**., as applicable.
   - **C. Endorsement of State Health Department Official.**
3. Physical Address in the United States where the applicant plans to reside:

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

City or Town | State | ZIP Code

Section B. Applicant's Statement

Upon admission to the United States, I will:

1. ☐ Go directly to the physician or health facility named in **Item Number 6.** of **Section C.**;
2. ☐ Present copies of diagnostic tests used during my visa examination to verify my diagnosis;
3. ☐ Attend counseling and examinations, treatment and medical regimen as required; and
4. ☐ Remain under prescribed treatment or observation, regardless of whether I am on an inpatient or an outpatient basis, until I am discharged.
5. Applicant's Signature | Date of Signature *(mm/dd/yyyy)* ►

Section C. Statement by Physician or Health Facility

1. I agree to supply counseling and any treatment or observation necessary for the proper management and continued care of the applicant's tuberculosis condition.
2. I agree to submit a summary of my initial evaluation of the applicant's condition, indicating presumptive diagnosis, test results, and plans for the applicant's future care, to:

The Division of Global Migration and Quarantine (E03)
Centers for Disease Control and Prevention
Atlanta, Georgia 30333

Section C. Statement by Physician or Health Facility (continued)

A. I will submit the summary referenced above within 30 days of the date the applicant is required to appear for evaluation and/or care; and

B. If at the end of the 30-day period the applicant fails to appear for evaluation and/or care as required, I will submit a report to notify the CDC and the health official indicated in **Section D**. of the applicant's failure to appear.

3. Satisfactory financial arrangements have been made for the applicant's medical care and treatment. (The applicant must still submit evidence, as required by the consular officer or USCIS, to establish that he or she is unlikely to become a public charge (another ground of inadmissibility under section 212(a)(4) of the Immigration and Nationality Act).

4. I represent: (Select the appropriate box and provide the information requested below.)

A. ☐ Local Health Department

B. ☐ Other Public Health Facility

C. ☐ Private Medical Practice

5. ☐ I agree to submit a copy of my evaluation to the health official indicated in **Section D.**

6. Name of Physician

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

Name of Facility

7. Address of Physician or Facility

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

City or Town | State | ZIP Code

8. Signature of Physician | Date of Signature *(mm/dd/yyyy)* ▶

Section D. Endorsement of State Health Department Official

Your endorsement signifies that you recognize the physician or facility providing the applicant's treatment for tuberculosis. If the facility physician who signed in **Section C.** is not in your health jurisdiction or is not familiar to you, you may wish to contact the health officer responsible for the jurisdiction, and/or the physician, before you sign this endorsement.

1. Official Name of Department and Name and Title of Official Providing Endorsement (Type or Print)

2. Signature of State Health Department Official | Date of Signature *(mm/dd/yyyy)* ▶

3. Address of Health Department

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

City or Town | State | ZIP Code