Form I-690 Supplement to Form TOC,

Supplement 1,

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

OMB RIN: 1615-0032

7/05/2014

Reason for Revision:

Current Location	**Current Text**	**Proposed Text**
Page 2, **Supplement for Applicants With Tuberculosis (TB)** ***Part A. Applicant's Sponsor in the United States***		Page 1, **Supplement 1., Applicants With a Class A Tuberculosis Condition (As Defined by Health and Human Services Regulations)** **[new]** **Applicant's Name and Alien Registration Number (A-Number)(if any)** 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 **Part C.**	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 state or local health department**: If a state or local health department will provide the	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

	necessary care and/or treatment to the applicant, that facility should check block (a) in Number4 under Part C. The health department is not required to complete anything else on this form. b. **Treatment is being provided by a private physician or by any other private or public facility**: If a private physician, private medical facility or a public medical facility (other than a state or local health department) will provide the applicant's medical care and/or treatment, that facility should check block (b) or (c) under Number 4 of Part C, as applicable. In that case, the state or local health department in the jurisdiction where the applicant will reside must complete Part D. 3. Address in the United States where the applicant plans to reside: Address (*Number and Street*) (*Apartment No.)* City, State and Zip Code	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
Page 2, ***Part B. Applicant's Statement***	Upon admission to the United States, I will: 1. Go directly to the physician or	Page 1, **Section B. Applicant's Statement** Upon admission to the United States, I will: 1.__ Go directly to the physician or

	health facility named in Number 5 of Part C. 2. Present copies of diagnostic tests used on the visa examination to substantiate diagnosis; 3. Submit to counseling and such examinations, treatment and medical regimen as may be required; and 4. Remain under prescribed treatment or observation whether on inpatient or outpatient basis, until discharged.	health facility named in **Item Number 6** of **Section 3.** 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*)
Page 2, ***Part C. Statement by Physician or Health Facility***	1. I agree to supply counseling and any treatment or observation necessary for the proper management of the applicant's condition. 2. I agree to submit a copy of my evaluation to the Division of Global Migration and Quarantine (E03), Centers for Disease Control and Prevention, Atlanta, Georgia 30333, and certify the following: a. I will submit a copy of my evaluation within 30 days of the date the applicant is required to appear for evaluation and/or care; and	Page 1, **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 Quarentine (E03) Centers for Disease Control and Prevention Atlanta, Georgia 30333 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;

	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 that effect to the CDC.	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. (This statement does not relieve the applicant from submitting evidence, as required by the consular officer or USCIS, to establish that he or she is not likely to become a public charge (another ground of inadmissibility under section 212(a)(4) of the Immigration and Nationality Act.)	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: (*Check the appropriate box and provide the information requested below*.) a. Local Health Department b. Other Public Health Facility c. Private Medical Practice	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 officer indicated in Part D. (*Required if you checked block (b) or (c) in Number 4 directly above.*)	5. I agree to submit a copy of my evaluation to the health official indicated in **Section D.**
	Name of Physician or Facility (Please type or print)	6. Name of Physician Family Name (Last Name) Given Name (First Name) Middle Name (if applicable)

	Address (Number and Street) City, State, and Zip Code Signature of Physician Date	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*)
Page 2, ***Part D. Endorsement of Local or State Health Officer:***	Endorsement signifies recognition of the physician or facility for the purpose of providing care for tuberculosis. If the facility physician who signed in Part **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. Official Name of Department (Please type or print) Signature Date Name of Health Department to receive the required notice from the CDC following the Applicant's arrival in the United States/adjustment of status. *(Please type or print.)*	Page 2, **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*)

	Address (*Number and Street*) City, State and Zip Code	3.Address of Health Department Street Number and Name Apt. Ste. Flr. Number City or Town State ZIP Code