

**TABLE OF CHANGES – FORM**  
**Form I-910, Application for Civil Surgeon Designation**  
**OMB Number: 1615-0114**  
**04/20/2020**

**Reason for Revision:**

Legend for Proposed Text:

- Black font = Current text
- **Red font** = Changes

Expires 05/31/2020

Edition Date 05/29/2018

Current Page Number and Section	Current Text	Proposed Text
<b>Page 1, For USCIS Use Only</b>	<p>[Page 1]</p> <p><b>For USCIS Use Only</b></p> <p><b>Initial Receipt Resubmitted</b></p> <p><b>Received Sent</b></p> <p><b>Barcode Remarks CSID Number</b></p> <p><b>Action Block</b></p> <p><b>To be completed by an attorney or accredited representative (if any).</b></p> <p><b>Select this box if Form G-28 is attached to represent the applicant.</b></p> <p><b>Attorney State Bar Number (if applicable)</b></p> <p><b>Attorney or Accredited Representative USCIS Online Account Number (if any)</b></p> <p><b>START HERE - Type or print in black ink.</b></p>	<p>[no change]</p>
<b>Page 1-2, Part 1. Information About You (The Applicant)</b>	<p>[Page 1]</p> <p><b>Part 1. Information About You (The Applicant)</b></p> <p><b>1.a. Have you ever been designated as a civil surgeon?</b> Yes</p>	<p>[no change]</p> <p><b>1. Have you ever been designated as a civil surgeon?</b> Yes</p>

	<p>No</p> <p>If you answered "Yes" to <b>Item Number 1.a.</b>, provide the following information.</p> <p><b>1.d.</b> Civil Surgeon Identification Number (CSID) (if known)</p> <p><b>1.b.</b> Period of Designation (mm/dd/yyyy) From To</p> <p><b>1.c.</b> U.S. Citizenship and Immigration Services (USCIS) Office That Granted the Designation</p> <p><b>2.a.</b> Has USCIS ever revoked your designation? Yes No</p> <p>If you answered "Yes" to <b>Item Number 2.a.</b>, provide the following information.</p> <p><b>2.b.</b> Date of Revocation (mm/dd/yyyy)</p> <p><b>3.a.</b> Have you ever voluntarily terminated your designation? Yes No</p> <p>If you answered "Yes" to <b>Item Number 3.a.</b>, provide the following information.</p> <p><b>3.b.</b> Date of Voluntary Termination (mm/dd/yyyy)</p> <p><b>NOTE:</b> If you answered "Yes" to <b>Item Number 2.a.</b> or <b>Item Number 3.a.</b>, include a typed or printed explanation of the circumstances surrounding the revocation or voluntary termination in <b>Part 9. Additional Information.</b></p> <p><b>Your Full Name</b></p> <p><b>4.a.</b> Family Name (Last Name) <b>4.b.</b> Given Name (First Name) <b>4.c.</b> Middle Name</p> <p><b>Other Names Used</b> List all other names you have ever used, including aliases, maiden name, and nicknames. If you need extra space to complete this section, use the space provided in <b>Part 9. Additional Information.</b></p> <p><b>5.a.</b> Family Name (Last Name)</p>	<p>No</p> <p>If you answered "Yes" to <b>Item Number 1.</b>, provide the following information.</p> <p><b>2.</b> Civil Surgeon Identification Number (CSID) (if known)</p> <p><b>3.</b> Period of Designation (mm/dd/yyyy) From To</p> <p>[deleted]</p> <p><b>4.</b> Has USCIS ever revoked your designation? Yes No</p> <p>If you answered "Yes" to <b>Item Number 4.</b>, provide the following information.</p> <p><b>5.</b> Date of Revocation (mm/dd/yyyy)</p> <p><b>6.</b> Have you ever voluntarily terminated your designation? Yes No</p> <p>If you answered "Yes" to <b>Item Number 6.</b>, provide the following information.</p> <p><b>7.</b> Date of Voluntary Termination (mm/dd/yyyy)</p> <p><b>NOTE:</b> If you answered "Yes" to <b>Item Number 4.</b> or <b>Item Number 6.</b>, include a typed or printed explanation of the circumstances surrounding the revocation or voluntary termination in <b>Part 10. Additional Information.</b></p> <p><b>8.</b> Your Full Legal Name (Do not provide a nickname) Family Name (Last Name) Given Name (First Name) Middle Name (if applicable)</p> <p>[Page 2]</p> <p><b>9.</b> Other Names Used (if any)</p> <p><b>Provide</b> all other names you have ever used, including aliases, maiden name, and nicknames. If you need extra space to complete this section, use the space provided in <b>Part 10. Additional Information.</b></p>
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	<p><b>5.b.</b> Given Name (First Name)  <b>5.c.</b> Middle Name</p> <p><i>Other Information</i>  <b>6.</b> Date of Birth (mm/dd/yyyy)</p> <p><b>7.</b> Gender  Male  Female</p> <p><b>[Page 2]</b></p> <p><b>8.</b> USCIS Online Account Number (if any)</p> <p><b>9.</b> Alien Registration Number (A-Number) (if any)</p>	<p>Family Name (Last Name)[x2]  Given Name (First Name)[x2]  Middle Name (if applicable)[x2]</p> <p><i>Other Information</i>  <b>10.</b> Date of Birth (mm/dd/yyyy)</p> <p><b>11.</b> Gender  Male  Female</p> <p><b>12.</b> USCIS Online Account Number (if any)</p> <p><b>13.</b> Alien Registration Number (A-Number) (if any)</p>
<p><b>Page 2,</b>  <b>Part 2. Clinical Office Locations</b></p>	<p><b>[Page 2]</b></p> <p><b>Part 2. Clinical Office Locations</b></p> <p>Provide the following information about the locations where you seek to perform immigration medical examinations. If you seek to perform immigration medical exams in more than one location, provide the details for each additional location in the space provided in <b>Part 9. Additional Information.</b></p> <p><i>Name and Physical Address of the Clinic/Practice</i></p> <p>You must provide the following information. Failure to provide this information may result in the denial of your application. See the <b>Additional Office Information</b> section below for more information about what will be made publicly available.</p> <p><b>1.</b> Name of the Clinic/Practice</p> <p><b>2.a.</b> Street Number and Name  <b>2.b.</b> Apt./Ste./Flr. [Number]  <b>2.c.</b> City or town  <b>2.d.</b> State  <b>2.e.</b> ZIP Code</p> <p><b>3.</b> Telephone Number  <b>4.</b> Fax Number  <b>5.</b> Email Address (For Use By USCIS)</p>	<p><b>[Page 2]</b></p> <p>[no change]</p> <p>Provide the following information about the locations where you seek to perform immigration medical examinations. If you seek to perform immigration medical <b>examinations</b> in more than one location, provide the details for each additional location in the space provided in <b>Part 10. Additional Information.</b></p> <p>[deleted]</p> <p>You must provide the following information. Failure to provide this information may result in the denial of your application. <b>USCIS displays information regarding a clinic/practice location and contact information on our website for people who want to find a civil surgeon. USCIS will use the contact information listed below for all civil surgeon-related communications.</b></p> <p><b>1.</b> Name of the Clinic/Practice</p> <p><b>2. Physical Address of the Clinic/Practice</b>  Street Number and Name  Apt./Ste./Flr. [Number]  City or town  State  ZIP Code</p> <p><b>3. County of Practice</b>  <b>4.</b> Telephone Number  <b>5.</b> Fax Number (if any)  <b>6.</b> Email Address</p> <p>[deleted]</p>

	<p><b>NOTE:</b> USCIS will use the contact information listed above for all civil surgeon-related communication.</p> <p><b>UPDATE USCIS OF ANY CHANGES:</b> Civil surgeons are responsible for notifying USCIS in writing of any updates to the contact information provided in this application <b>within 15 days of the change</b>. Visit the USCIS website at <a href="http://www.uscis.gov/I-910">www.uscis.gov/I-910</a> for information on how to submit a change.</p> <p><b>Additional Office Information</b> Your application will not be affected if you choose not to provide the following information. USCIS displays this information on our website for people who want to find a civil surgeon.</p> <p>6. Email Address (For Use By The Public) 7. Website Address (URL) 8. Fees for Medical Examination 9. Acceptable Means of Payment 10. Accepted Medical Insurance Plans 11. Languages Spoken 12. Office Hours 13. Handicap Accessibility 14. Other</p>	<p>7. Website Address (URL) (if any) [deleted]</p> <p>8. Additional Languages Spoken (if any) [deleted]</p> <p>9. Physician Email Address (for USCIS use)</p> <p>10. Is the clinic's physical address the same as the clinic's mailing address? Y/N</p> <p>If you answered "No" to <b>Item Number 10.</b>, provide the clinic's mailing address in <b>Item Number 11.</b></p> <p>[Page 3]</p> <p>11. Mailing Address of the Clinic/Practice In Care Of Name (if any) Street Number and Name Apt./Ste./Flr. [Number] City or town County State ZIP Code</p>
<p>Page 2-3, Part 3. Information About Your Status in the United States</p>	<p>[Page 2]</p> <p><b>Part 3. Information About Your Status in the United States</b></p> <p>You must be authorized to work in the United States to be eligible for civil surgeon designation. Select the box that accurately states how you are authorized to work in the United States. (Select <b>only one</b> box.)</p> <p>1. I am a U.S. citizen or national.</p>	<p>[Page 3]</p> <p>[no change]</p> <p>1. I am a U.S. citizen or national.</p>

	<p>(Attach proof that you are a U.S. citizen or national, such as a copy of a U.S. passport, birth certificate, or Certificate of Naturalization.)</p> <p><b>2.</b> I am a Lawful Permanent Resident. (Attach a copy of your valid Form I-551, Permanent Resident Card. If you are currently seeking to renew or replace your Form I-551, attach evidence showing that you are doing so.)</p> <p><b>[Page 3]</b></p> <p><b>3.a.</b> I am currently present in the United States as a nonimmigrant. (Attach a copy of your Form I-94 Arrival-Departure Record, a copy of your passport or travel document, and any documents related to your nonimmigrant status, such as a copy of the petition, petition approval, and change or extension of status application. Also attach a copy of your valid, unexpired Employment Authorization Document as proof of your authorization to work in the United States, if required.)</p> <p><b>3.b.</b> Date of Last Arrival in the U.S. (mm/dd/yyyy)</p> <p><b>3.c.</b> Form I-94 Arrival-Departure Record Number (if any)</p> <p><b>3.d.</b> Passport Number</p> <p><b>3.e.</b> Travel Document Number</p> <p><b>3.f.</b> Country of Issuance for Passport or Travel Document</p> <p><b>3.g.</b> Expiration Date for Passport or Travel Document (mm/dd/yyyy)</p> <p><b>3.h.</b> Current Nonimmigrant Status</p> <p><b>4.</b> I have an Employment Authorization Document (EAD) granted by USCIS that authorizes me to work in the United States. (Attach a copy of your valid, unexpired EAD as proof of your authorization to work in the United States.)</p>	<p>(Attach proof that you are a U.S. citizen or national, such as a copy of an <b>unexpired</b> U.S. passport, birth certificate, or Certificate of Naturalization.)</p> <p><b>2.</b> I am a <b>lawful permanent resident</b>. (Attach a copy of your valid Form I-551, Permanent Resident Card. If you are currently seeking to renew or replace your Form I-551, attach evidence showing that you are doing so.)</p> <p><b>3.A.</b> I am currently present in the United States as a nonimmigrant. <b>Provide the information requested in Items B. - H. in Item Number 3.</b> (Attach a copy of your Form I-94 Arrival-Departure Record, a copy of your passport or travel document, and any documents related to your nonimmigrant status, such as a copy of the petition, petition approval, and change or extension of status application. Also attach a copy of your valid, unexpired Employment Authorization Document as proof of your authorization to work in the United States, if required.)</p> <p><b>B.</b> Date of Last Arrival in the U.S. (mm/dd/yyyy)</p> <p><b>C.</b> Form I-94 Arrival-Departure Record Number (if any)</p> <p><b>D.</b> Passport or Travel Document Number</p> <p><b>[delete]</b></p> <p><b>E.</b> Country of Issuance for Passport or Travel Document</p> <p><b>F.</b> Expiration Date for Passport or Travel Document (mm/dd/yyyy)</p> <p><b>G.</b> Current Nonimmigrant Status</p> <p><b>H.</b> I have an Employment Authorization Document (EAD) granted by USCIS that authorizes me to work in the United States. (Attach a copy of your valid, unexpired EAD as proof of your authorization to work in the United States.) <b>Yes</b> <b>No</b></p>
<p><b>Page 3,</b> <b>Part 5. Medical Degrees</b></p>	<p><b>[Page 3]</b></p> <p><b>Part 5. Medical Degrees</b></p> <p>You must possess a medical degree as a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) to be eligible for civil surgeon</p>	<p><b>[Page 3]</b></p> <p><b>Part 4. Medical Degrees</b></p> <p>You must possess a medical degree as a <b>doctor</b> of <b>medicine</b> (M.D.) or <b>doctor</b> of <b>osteopathy</b> (D.O.) to be eligible for civil surgeon</p>

	<p>designation. <b>Attach a copy of each medical degree listed below.</b> If you need extra space to complete this section, use the space provided in <b>Part 9. Additional Information.</b></p> <p><b>School 1</b>  <b>1.a.</b> School Name  <b>1.b.</b> Dates of Attendance (mm/dd/yyyy)  From  To  <b>1.c.</b> Degree</p> <p><b>School 2</b>  <b>2.a.</b> School Name  <b>2.b.</b> Dates of Attendance (mm/dd/yyyy)  From  To  <b>2.c.</b> Degree</p>	<p>designation. <b>Attach a copy of your medical degree and complete the chart below.</b></p> <p>[Table, 4 columns, 3 rows]  <b>Name of School</b>  <b>Dates of Attendance (mm/dd/yyyy) From To</b>  <b>Graduation Date (mm/dd/yyyy)</b>  <b>Degree</b></p>
<b>Page 3,</b> <b>Part 4. Medical Licenses</b>	<p>[Page 3]</p> <p><b>Part 4. Medical Licenses</b></p> <p>You must be licensed to practice medicine in the state or U.S. territory in which you seek to perform immigration medical examinations to be eligible for civil surgeon designation. <b>Attach a copy of each medical license listed below.</b> If you need extra space to complete this section, use the space provided in <b>Part 9. Additional Information.</b></p> <p><b>Medical License 1</b>  <b>1.a.</b> State or U.S. Territory  <b>1.b.</b> Medical License Number  <b>1.c.</b> Date Issued (mm/dd/yyyy)  <b>1.d.</b> Date Expires (mm/dd/yyyy)</p> <p><b>Medical License 2</b>  <b>2.a.</b> State or U.S. Territory  <b>2.b.</b> Medical License Number  <b>2.c.</b> Date Issued (mm/dd/yyyy)  <b>2.d.</b> Date Expires (mm/dd/yyyy)</p>	<p>[Page 4]</p> <p><b>Part 5. Medical Licenses</b></p> <p>You must <b>have an active and unrestricted license</b> to practice medicine in the state or U.S. territory <b>where</b> you seek to perform immigration medical examinations to be eligible for civil surgeon designation. <b>Attach a copy of each medical license listed below.</b> If you need extra space to complete this section, use the space provided in <b>Part 9. Additional Information.</b></p> <p>[Table, 5 columns, 4 rows]  <b>State or U.S. Territory</b>  <b>Medical License Number</b>  <b>Date Issue (mm/dd/yyyy)</b>  <b>Date Expires (mm/dd/yyyy)</b>  <b>Good Standing? (Y/N)</b></p> <p>If your medical license is restricted, temporary, or not in good standing; include any relevant documentation and a typed or printed explanation of the circumstances in <b>Part 10. Additional Information.</b></p>
<b>Page 4,</b> <b>Professional Experience</b>	<p>[Page 4]</p> <p><b>Part 6. Professional Experience</b></p> <p>You must establish that you have practiced medicine as a physician (M.D. or D.O.) for at least four years to be eligible for designation.</p>	<p>[Page 4]</p> <p><b>Part 6. Professional Experience</b></p> <p>You must establish that you have practiced medicine as a physician (M.D. or D.O.) <b>in the U.S.</b> for at least four years to be eligible for designation.</p>

	<p><b>NOTE:</b> In calculating whether you meet the requirement of four years of practice as a physician, do <b>NOT</b> count your post graduate medical training in an internship or residency program. You can, however, count the time you practiced medicine on the basis of a post-residency fellowship.</p> <p>Submit evidence to establish your professional experience, such as evaluations, certificates of completion, business tax returns and business license (for self-employed physicians), or letters of employment verification. If you need extra space to complete this section, use the space provided in <b>Part 9. Additional Information.</b></p> <p><b>Employer 1</b>  <b>1.a.</b> Employer's Name</p> <p><b>1.b.</b> Dates of Employment (mm/dd/yyyy)  From  To</p> <p><b>1.h.</b> Employer's Daytime Telephone Number</p> <p><b>1.c.</b> Street Number and Name  <b>1.d.</b> Apt./Ste./Flr. [Number]  <b>1.e.</b> City or Town  <b>1.f.</b> State  <b>1.g.</b> ZIP Code</p> <p><b>Employer 2</b>  <b>2.a.</b> Employer's Name</p> <p><b>2.b.</b> Dates of Employment (mm/dd/yyyy)  From  To</p> <p><b>2.c.</b> Street Number and Name  <b>2.d.</b> Apt./Ste./Flr. [Number]  <b>2.e.</b> City or Town  <b>2.f.</b> State  <b>2.g.</b> ZIP Code  <b>2.h.</b> Employer's Daytime Telephone Number</p>	<p><b>NOTE:</b> In calculating whether you meet the requirement of four years of practice as a physician, do <b>NOT</b> count your post graduate medical training in an internship or residency program. You can, however, count the time you practiced medicine on the basis of a post-residency fellowship.</p> <p>Submit evidence to establish your professional experience, such as <b>letters of employment verification</b>, evaluations, certificates of completion, <b>business tax returns and the business license covering tax returns period</b> (for self-employed physicians), <b>or medical liability or malpractice insurance policy. A medical liability/malpractice insurance policy, by itself, is insufficient to establish professional experience, but may be submitted to supplement other evidence listed above.</b> If you need extra space to complete this section, use the space provided in <b>Part 10. Additional Information.</b></p> <p><b>Employer 1</b>  <b>1.</b> Employer's Name</p> <p>Dates of Employment (mm/dd/yyyy)  From  To</p> <p>Employer's Daytime Telephone Number</p> <p><b>Employer's Address</b>  Street Number and Name  Apt./Ste./Flr. [Number]  City or Town  State  ZIP Code</p> <p><b>[Page 5]</b></p> <p><b>Employer 2</b>  <b>2.</b> Employer's Name</p> <p>Dates of Employment (mm/dd/yyyy)  From  To</p> <p>Employer's Daytime Telephone Number</p> <p><b>Employer's Address</b>  Street Number and Name  Apt./Ste./Flr. [Number]  City or Town  State  ZIP Code</p>
<b>Page 4-5,  Part 7. Applicant's  Statement, Contact  Information, Declaration,  Certification, and Signature</b>	<b>[Page 4]</b> <b>Part 7. Applicant's Statement, Contact  Information, Declaration, Certification, and  Signature</b>	<b>[Page 5]</b> <b>Part 7. Applicant's Statement, Contact  Information, Certification, and Signature</b>





	<p>Copies of any documents I have submitted are exact photocopies of unaltered, original documents, and I understand that USCIS may require that I submit original documents to USCIS at a later date. Furthermore, I authorize the release of any information from any and all of my records that USCIS may need to determine my eligibility for designation as a civil surgeon.</p> <p>I furthermore authorize release of information contained in this application, in supporting documents, and in my USCIS records, to other entities and persons where necessary for the administration and enforcement of U.S. immigration law.</p> <p><b>[Page 5]</b></p> <p>I certify, under penalty of perjury, that all of the information in my application and any document submitted with it were provided or authorized by me, that I reviewed and understand all of the information contained in, and submitted with, my application and that all of this information is complete, true, and correct.</p> <p><b><i>Applicant's Signature</i></b>  <b>5.a.</b> Applicant's Signature  <b>5.b.</b> Date of Signature (mm/dd/yyyy)</p> <p><b>NOTE TO ALL APPLICANTS:</b> If you do not completely fill out this application or fail to submit required documents listed in the Instructions, USCIS may deny your application.</p>	<p>I certify, under penalty of perjury, that <b>I provided or authorized</b> all of the information in my application, <b>I understand all of the information contained in, and submitted with, my application, and that all of this</b> information is complete, true, and correct.</p> <p><b>Applicant's Signature</b>  <b>6.</b> Applicant's Signature  Date of Signature (mm/dd/yyyy)</p> <p>Your signature will be kept on record to verify the signature on any submitted Form I-693.</p> <p>[no change]</p>
		<p><b>[Page 6]</b></p> <p><b>Part 8. Interpreter's Contact Information, Certification, and Signature</b></p> <p>Provide the following information about the interpreter.</p> <p><b>Interpreter's Full Name</b>  <b>1.</b> Interpreter's Family Name (Last Name)  Interpreter's Given Name (First Name)</p> <p><b>2.</b> Interpreter's Business or Organization Name (if any)</p> <p><b>Interpreter's Mailing Address</b>  <b>3.</b> Street Number and Name  Apt./Ste./Flr. Number  City or Town</p>

		<p>State ZIP Code Province Postal Code Country</p> <p>[Page 7]</p> <p><b>Interpreter's Contact Information</b>  <b>4.</b> Interpreter's Daytime Telephone Number  <b>5.</b> Interpreter's Mobile Telephone Number (if any)  <b>6.</b> Interpreter's Email Address (if any)</p> <p><b>Interpreter's Certification</b>  I certify, under penalty of perjury, that:</p> <p>I am fluent in English and [Fillable Field], which is the same language specified in <b>Part 7., Item B. in Item Number 1.</b>, and I have read to this applicant in the identified language every question and instruction on this application and his or her answer to every question. The applicant informed me that he or she understands every instruction, question, and answer on the application, including the <b>Applicant's Certification</b>, and has verified the accuracy of every answer.</p> <p><b>Interpreter's Signature</b>  <b>7.</b> Interpreter's Signature  Date of Signature (mm/dd/yyyy)</p>
<p>Page 5, Part 8. Contact Information, Declaration, and Signature of the Person Preparing this Application, if Other Than the Applicant</p>	<p>[Page 5]</p> <p><b>Part 8. Contact Information, Declaration, and Signature of the Person Preparing this Application, if Other Than the Applicant</b></p> <p>Provide the following information about the preparer.</p> <p><b>Preparer's Full Name</b>  <b>1.a.</b> Preparer's Family Name (Last Name)  <b>1.b.</b> Preparer's Given Name (First Name)  <b>2.</b> Preparer's Business or Organization Name (if any)</p> <p><b>Preparer's Mailing Address</b>  <b>3.a.</b> Street Number and Name  <b>3.b.</b> Apt./Ste./Flr. [Number]  <b>3.c.</b> City or Town  <b>3.d.</b> State  <b>3.e.</b> ZIP Code  <b>3.f.</b> Province  <b>3.g.</b> Postal Code  <b>3.h.</b> Country</p>	<p>[Page 7]</p> <p><b>Part 9. Contact Information, Declaration, and Signature of the Person Preparing this Application, if Other Than the Applicant</b></p> <p>[no change]</p> <p><b>Preparer's Full Name</b>  <b>1.</b> Preparer's Family Name (Last Name)  Preparer's Given Name (First Name)  <b>2.</b> Preparer's Business or Organization Name (if any)</p> <p><b>Preparer's Mailing Address</b>  <b>3.</b> Street Number and Name  Apt./Ste./Flr. [Number]  City or Town  State  ZIP Code  Province  Postal Code  Country</p> <p>[Page 8]</p>

	<p><b>Preparer's Contact Information</b></p> <p>4. Preparer's Daytime Telephone Number</p> <p>5. Preparer's Mobile Telephone Number (if any)</p> <p>6. Preparer's Email Address (if any)</p> <p>7. Select this box if the preparer may act as a secondary point of contact for you. USCIS will contact this preparer if you cannot be reached using the information in <b>Part 2</b>.</p> <p><b>Preparer's Statement</b></p> <p>8.a. I am not an attorney or accredited representative but have prepared this application on behalf of the applicant and with the applicant's consent.</p> <p>8.b. I am an attorney or accredited representative and my representation of the applicant in this case extends/does not extend beyond the preparation of this application.</p> <p><b>NOTE:</b> If you are an attorney or accredited representative, you may need to submit a completed Form G-28, Notice of Entry of Appearance as Attorney or Accredited Representative, with this application.</p> <p><b>Preparer's Certification</b></p> <p>By my signature, I certify, under penalty of perjury, that I prepared this application at the request of the applicant. The applicant then reviewed this completed application and informed me that he or she understands all of the information contained in, and submitted with, his or her application, including the <b>Applicant's Declaration and Certification</b>, and that all of this information is complete, true, and correct. I completed this application based only on information that the applicant provided to me or authorized me to obtain or use.</p> <p><b>Preparer's Signature</b></p> <p>9.a. Preparer's Signature</p> <p>9.b. Date of Signature (mm/dd/yyyy)</p>	<p>[no change]</p> <p><b>Preparer's Statement</b></p> <p>8.A. I am not an attorney or accredited representative but have prepared this application on behalf of the applicant and with the applicant's consent.</p> <p>B. I am an attorney or accredited representative and my representation of the applicant in this case extends/does not extend beyond the preparation of this application.</p> <p>[no change]</p> <p><b>Preparer's Certification</b></p> <p>By my signature, I certify, under penalty of perjury, that I prepared this application at the request of the applicant. The applicant then reviewed this completed application and informed me that he or she understands all of the information contained in, and submitted with, his or her application, including the <b>Applicant's Certification</b>, and that all of this information is complete, true, and correct. I completed this application based only on information that the applicant provided to me or authorized me to obtain or use.</p> <p><b>Preparer's Signature</b></p> <p>9. Preparer's Signature</p> <p>Date of Signature (mm/dd/yyyy)</p>
<p>Page 6, Part 9. Additional Information</p>	<p>[Page 6]</p> <p><b>Part 9. Additional Information</b></p> <p>If you need extra space to provide any additional information within this application, use the space below. If you need more space than what is provided, you may make copies of this page to complete and file with this application or attach a separate sheet of paper. Type or print your name and CSID Number (if any) at the top of each sheet; indicate the <b>Page Number</b>, <b>Part Number</b>, and</p>	<p>[Page 9]</p> <p><b>Part 10. Additional Information</b></p>

	<p><b>Item Number</b> to which your answer refers; and sign and date each sheet.</p> <p><b>1.a.</b> Family Name (Last Name)</p> <p><b>1.b.</b> Given Name (First Name)</p> <p><b>1.c.</b> Middle Name</p> <p><b>2.</b> CSID Number (if any) [Auto-populate field with <b>Item Number 1.d.</b> in <b>Part 1.</b>]</p> <p><b>3.a.</b> Page Number  <b>3.b.</b> Part Number  <b>3.c.</b> Item Number  <b>3.d.</b> [Fillable field]</p> <p><b>4.a.</b> Page Number  <b>4.b.</b> Part Number  <b>4.c.</b> Item Number  <b>4.d.</b> [Fillable field]</p> <p><b>5.a.</b> Page Number  <b>5.b.</b> Part Number  <b>5.c.</b> Item Number  <b>5.d.</b> [Fillable field]</p> <p><b>6.a.</b> Page Number  <b>6.b.</b> Part Number  <b>6.c.</b> Item Number  <b>6.d.</b> [Fillable field]</p> <p><b>7.a.</b> Page Number  <b>7.b.</b> Part Number  <b>7.c.</b> Item Number  <b>7.d.</b> [Fillable field]</p>	<p><b>1.</b> Family Name (Last Name)[Auto-populated field]  Given Name (First Name)[Auto-populated field]  Middle Name[Auto-populated field]</p> <p><b>2.</b> CSID Number (if any) [Auto-populate field with <b>Item Number 2.</b> in <b>Part 1.</b>]</p> <p><b>3.A.</b> Page Number  <b>B.</b> Part Number  <b>C.</b> Item Number  <b>D.</b> [Fillable field]</p> <p><b>4.A.</b> Page Number  <b>B.</b> Part Number  <b>C.</b> Item Number  <b>D.</b> [Fillable field]</p> <p><b>5.A.</b> Page Number  <b>B.</b> Part Number  <b>C.</b> Item Number  <b>D.</b> [Fillable field]</p> <p><b>6.A.</b> Page Number  <b>B.</b> Part Number  <b>C.</b> Item Number  <b>D.</b> [Fillable field]</p> <p><b>7.A.</b> Page Number  <b>B.</b> Part Number  <b>C.</b> Item Number  <b>D.</b> [Fillable field]</p>
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