TABLE OF CHANGES – FORM
Form I-693, Report of Medical Examination and Vaccination Record
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- Black font = Current text
- Red font = Changes

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Current Page Number and Section	Current Text	Proposed Text
Page 1, Part 1. Information About You (To be completed by the person requesting a medical examination, **NOT** the civil surgeon)	**[Page 1]** **START HERE- Type or print in black ink.** **Part 1. Information About You** (To be completed by the person requesting a medical examination, **NOT** the civil surgeon) **1. Your Full Name** Family Name (Last Name) Given Name (First Name) Middle Name **2. Physical Address** Street Number and Name Apt. Ste. Flr. Number City or Town State ZIP Code **3. Other Information** **A.** Gender Male Female **B.** Date of Birth (mm/dd/yyyy) **C.** City/Town/Village of Birth **D.** Country of Birth **E.** Alien Registration Number (A-Number) (if any) **F.** USCIS Online Account Number (if any)	**[Page 1]** **START HERE - Type or print in black ink.** **Part 1. Information About You** (To be completed by the person requesting a medical examination, **NOT** the civil surgeon) **1.** Your Full Legal Name (**Do not** provide a nickname) Family Name (Last Name) Given Name (First Name) Middle Name (if applicable) **2.** Current Physical Address In Care Of Name (if any) Street Number and Name Apt./Ste./Flr. Number City or Town State ZIP Code Province Postal Code Country **3.** Other Information **A.** Gender Male Female **B.** Date of Birth (mm/dd/yyyy) **C.** City/Town/Village of Birth **D.** Country of Birth **E.** Alien Registration Number (A-Number) (if any) **F.** USCIS Online Account Number (if any)
Pages 1-2, Part 2. Applicant's Statement, Contact	**[Page 1]** **Part 2. Applicant's Statement, Contact**	**[Page 1]** **Part 2. Applicant's Statement, Contact**

Information, Certification, and Signature	**Information, Certification, and Signature** **NOTE:** Read the **Penalties** section of the Form I-693 Instructions before completing this section. You must submit Form I-693 in a sealed envelope to USCIS as directed in the Form I-693 Instructions. ***Applicant's Statement*** … **[Page 2]** ***Applicant's Contact Information*** **3.** Applicant's Daytime Telephone Number **4.** Applicant's Mobile Telephone Number (if any) **5.** Applicant's Email Address (if any) ***Applicant's Certification*** I authorize the release of any information from any of my records that USCIS may need to determine my eligibility for the immigration benefit I seek. I further authorize release of information contained in this form, in supporting documents, and in my USCIS records to other entities and persons where necessary for the administration and enforcement of U.S. immigration laws. I understand that USCIS may require me to appear for an appointment to take my biometrics (fingerprints, photograph, and/or signature) and, at that time, if I am required to provide biometrics, I will be required to sign an oath reaffirming that: **1)** I reviewed and provided or authorized all of the information in my form; **2)** I understood all of the information contained in, and submitted with, my form; and **3)** All of this information was complete, true, and correct at the time of filing. I certify, under penalty of perjury that I am the	**Information, Certification, and Signature** **NOTE:** Read the **Penalties** section of the Form I-693 Instructions before completing this section. You must submit Form I-693 in a sealed envelope to USCIS as directed in the Form I-693 Instructions. Select the appropriate box to indicate whether you read this form yourself or whether you had an interpreter assist you. If someone assisted you in completing the form, select the box indicating that you used a preparer. ***Applicant's Statement*** … **[Page 2]** [deleted] ***Applicant's Certification*** 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 the immigration benefit I seek. I further authorize release of information contained in this form, in supporting documents, and in my USCIS records, to other entities and persons where necessary for the administration and enforcement of U.S. immigration laws. [deleted] I certify, under penalty of perjury that I am the

	person who is identified in **Part 1.** of this Form I-693, and that the information in **Part 1.** of this form is complete, true, and correct. I understand the purpose of this medical examination, 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 or altered information or documents with regard to my medical examination, I understand that any immigration benefit I derived from this medical examination may be revoked, that I may be removed from the United States, and that I may be subject to civil or criminal penalties. ***Applicant's Signature*** **NOTE: Do not sign or date Form I-693 until instructed to do so by the civil surgeon.** [new] **6.** Applicant's Signature Date of Signature (mm/dd/yyyy) **NOTE TO ALL APPLICANTS AND CIVIL SURGEONS:** If you or the civil surgeon do not completely fill out this form according to the instructions USCIS may deny your immigration benefit.	person who is identified in **Part 1.** of this Form I-693, and that the information in **Part 1.** of this form is complete, true, and correct. I understand the purpose of this immigration medical examination, 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 or altered information or documents with regard to my immigration medical examination, I understand that any immigration benefit I derived from this immigration medical examination may be revoked, that I may be removed from the United States, and that I may be subject to civil or criminal penalties. ***Applicant's Signature*** **NOTE: Do not sign or date Form I-693 until instructed to do so by the civil surgeon, at the beginning of the immigration medical examination, provided Parts 1. through 5. are completed.** You must sign and date your form. Every form **MUST** contain the signature of the applicant (or parent or legal guardian, if applicable). A stamped or typewritten name in place of a signature is not acceptable. **3.** Applicant's Signature Date of Signature (mm/dd/yyyy) **NOTE TO ALL APPLICANTS AND CIVIL SURGEONS:** If you or the civil surgeon do not completely fill out this form or fail to submit required documents listed in the Instructions, USCIS may deny your immigration benefit application.
Pages 2-3, Part 3. Interpreter's Contact Information, Certification, and Signature	**[Page 2]** **Part 3. Interpreter's Contact Information, Certification, and Signature** Provide the following information about the interpreter, if you used one. [new] ***Interpreter's Full Name*** **…**	**[Page 2]** **Part 3. Interpreter's Contact Information, Certification, and Signature** [deleted] If you used anyone as an interpreter to read the Instructions and questions on this form to you in a language in which you are fluent, the interpreter must fill out this section. ***Interpreter's Full Name*** **…**
Pages 3-4, Part 4. Contact Information, Declaration, and	**[Page 3]** **Part 4. Contact Information, Declaration, and Signature of the Person Preparing this Application, if Other Than the Applicant**	**[Page 3]** **Part 4. Contact Information, Declaration, and Signature of the Person Preparing this Application, if Other Than the Applicant**

Statement of the Person Preparing this Application, if Other Than the Applicant	Provide the following information about the preparer. ***Preparer's Full Name*** **1.** Preparer's Family Name (Last Name) Preparer's Given Name (First Name) [new] **2.** Preparer's Business or Organization Name (if any) **[Page 4]** ***Preparer's Mailing Address*** **…** ***Preparer's Signature*** **[new]** **8.** Preparer's Signature Date of Signature (mm/dd/yyyy) **Parts 5. - 10. of this form must be completed by the civil surgeon.**	Provide the following information about the preparer. If the same individual acted as your interpreter **and** your preparer, that person should complete both **Part 3.** and **Part 4.** ***Preparer's Full Name*** **1.** Preparer's Family Name (Last Name) Preparer's Given Name (First Name) If the person who completed this application is associated with a business or organization, that person should complete the business or organization name and address information. **2.** Preparer's Business or Organization Name (if any) **[Page 4]** ***Preparer's Mailing Address*** **…** ***Preparer's Signature*** Anyone who helped you complete this form **MUST** sign and date the form. A stamped or typewritten name in place of a signature is not acceptable. **8.** Preparer's Signature Date of Signature (mm/dd/yyyy) **Parts 5. - 10. of this form must be completed by the civil surgeon.**
Page 5, **Part 6. Summary of Medical Examination** (To be completed by the civil surgeon)	**[Page 5]** **Part 6. Summary of Medical Examination** (To be completed by the civil surgeon) **1.** Summary of Overall Findings: **A. No Class A or Class B Condition** **B.** Class B Conditions (See **Item Numbers 1. - 4.** in **Part 8. Civil Surgeon Worksheet)** **C.** Class A Conditions (See **Item Numbers 1. - 3.** in **Part 8. Civil Surgeon Worksheet)** **2. Date of First Examination** (mm/dd/yyyy) **3. Dates of Follow-up Examinations, if required:** **Date of Examination** (mm/dd/yyyy) **Date of Examination** (mm/dd/yyyy) **Date of Examination** (mm/dd/yyyy)	**[Page 5]** **Part 6. Summary of Medical Examination** (To be completed by the civil surgeon) **1.** Summary of Overall Findings: **A. No Class A or Class B Condition** **B.** Class B Conditions (See **Item Numbers 1. - 4.** in **Part 8. Civil Surgeon Worksheet)** **C.** Class A Conditions (See **Item Numbers 1. - 3.** in **Part 8. Civil Surgeon Worksheet)** **2. Date of First Examination (Date applicant signed in Part 2)** (mm/dd/yyyy) **3. Dates of Follow-up Examinations, if required:** **Date of Examination** (mm/dd/yyyy) **Date of Examination** (mm/dd/yyyy) **Date of Examination** (mm/dd/yyyy)
Pages 5-6,	**[Page 5]** **Part 7. Civil Surgeon's Contact Information,**	**[Page 5]** **Part 7. Civil Surgeon's Contact Information,**

Part 7. Civil Surgeon's Contact Information, Certification, and Signature	**Certification, and Signature** **NOTE:** Do not sign Form I-693 and do not have the applicant sign in **Part 2.** until all health-related follow-up requirements are met. ***Civil Surgeon's Information*** **1.** Family Name (Last Name) Given Name (First Name) Middle Name **2.** Name of Medical Practice, Facility, or Health Department ***Physical Address*** **…** **[Page 6]** ***Civil Surgeon's Certification*** **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 United States 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 immigration-related medical examinations, unless otherwise exempted; I have not had my license to practice medicine revoked, and I am not subject to any restrictions on any license to practice medicine in any other jurisdiction in the United States in which I conduct immigration-related medical examinations. I performed an 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.**; I performed the examination in accordance with the Centers for Disease Control and Prevention's (CDC) Technical Instructions, as well as all supplemental information or updates; and All the information I provided on this Form I-693 is complete, true, and correct, based on the information provided to me by the applicant. ***Civil Surgeon's Signature***	**Certification, and Signature** **NOTE:** Do not sign Form I-693 and do not have the applicant sign in **Part 2.** until all health-related follow-up requirements are met. ***Civil Surgeon's Information*** **1.** Family Name (Last Name) Given Name (First Name) Middle Name (if applicable) Civil Surgeon Identification Number (CSID) (if any) **2.** Name of Medical Practice, Facility, or Health Department ***Physical Address*** **…** **[Page 6]** ***Civil Surgeon's Certification*** **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 United States 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 immigration medical examinations, unless otherwise exempted; I have not had my license to practice medicine revoked, and I am not subject to any restrictions on any license to practice medicine in any other jurisdiction in the United States in which I conduct immigration medical examinations. I performed an 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.**; I performed the examination in accordance with the Centers for Disease Control and Prevention's (CDC) *Technical Instructions for Civil Surgeons*, as well as all supplemental information or updates; and All the information I provided on this Form I-693 is complete, true, and correct, based on the information provided to me by the applicant. ***Civil Surgeon's Signature***

	8. Civil Surgeon's Signature Date of Signature (mm/dd/yyyy) ***(Health departments and military treatment facilities MUST place their official stamp or seal here)*** ***(official stamp or seal here)***	**8.** Civil Surgeon's Signature Date of Signature (mm/dd/yyyy) ***(Health departments and military treatment facilities MUST place their official stamp or seal here)*** ***(official stamp or seal here)***
Pages 7-11, Part 8. Civil Surgeon Worksheet	**[Page 7]** **Part 8. Civil Surgeon Worksheet** (To be completed by the civil surgeon, according to the Technical Instructions at **www.cdc.gov/immigrantrefugeehealth/exams/ti/civil/technical-instructions-civil-surgeons.html**) **1. Communicable Disease of Public Health Significance** **A. Tuberculosis (TB):** An initial screening test, 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 the Technical Instructions. The civil surgeon will perform further evaluation if needed (chest X-ray). **(1) Interferon Gamma Release Assay** (for acceptable IGRAs, consult the Technical Instructions and any updates posted on the CDC's website): Not administered (TST exception; please explain in Remarks section below) Select **only one** box. QuantiFERON Date Blood Sample Drawn (mm/dd/yyyy) T-Spot Date Blood Sample Drawn (mm/dd/yyyy) Result: Negative (no chest X-ray required) Positive (chest X-ray required) Indeterminate (including borderline/equivocal) (no chest X-ray required) **(2) Initial Screening Test Result and Chest X-Ray Determinations:** Chest X-ray not required (medically cleared for TB) Chest X-ray required due to initial screening test results Chest X-ray required due to TB signs or symptoms, or due to immunosuppression (such	**[Page 7]** **Part 8. Civil Surgeon Worksheet** (To be completed by the civil surgeon, according to the *Technical Instructions for Civil Surgeons* at **www.cdc.gov/immigrantrefugeehealth/exams/ti/civil/technical-instructions-civil-surgeons.html**) **1. Communicable Disease of Public Health Significance** **A. Tuberculosis (TB):** An initial screening test, 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 the *Technical Instructions for Civil Surgeons*. The civil surgeon will perform further evaluation if needed (chest X-ray). **(1) Interferon Gamma Release Assay** (for acceptable IGRAs, consult the *Technical Instructions for Civil Surgeons* and any updates posted on the CDC's website): Not administered (IGRA exception; please explain in Remarks section below) Select **only one** box. QuantiFERON Date Blood Sample Drawn (mm/dd/yyyy) T-Spot Date Blood Sample Drawn (mm/dd/yyyy) Result: Negative (no chest X-ray required) Positive (chest X-ray required) Indeterminate (including borderline/equivocal) (no chest X-ray required) **(2) Initial Screening Test Result and Chest X-Ray Determinations:** Chest X-ray not required (medically cleared for TB) Chest X-ray required due to initial screening test results Chest X-ray required due to TB signs or symptoms, or due to immunosuppression (such

	as HIV) Chest X-ray required due to IGRA exception (Clearly specify the IGRA exception in the Remarks section below.) [new] **(3) Chest X-Ray:** Required based on IGRA result, or if specific IGRA exceptions apply, or for an applicant with TB signs or symptoms or immunosuppression (such as HIV). Date Chest X-Ray Taken (mm/dd/yyyy) Date Chest X-Ray Read (mm/dd/yyyy) Result: Normal Abnormal (describe results in Remarks section below.) [new] TB Classification/Findings (Select only if chest	as HIV) Chest X-ray required due to IGRA exception (Clearly specify the IGRA exception in the Remarks section below.) **Sputum Smears and Cultures Results** **(3) Chest X-Ray:** Required based on IGRA result, or if specific IGRA exceptions apply, or for an applicant with TB signs or symptoms or immunosuppression (such as HIV). Date Chest X-Ray Taken (mm/dd/yyyy) Date Chest X-Ray Read (mm/dd/yyyy) Result: Normal Abnormal findings suggestive of TB that require smears and cultures: Infiltrate or consolidation Reticular markings suggestive of fibrosis Cavitary lesion Nodule(s) or mass with poorly defined margins (*such as tuberculoma)* Pleural effusion Hilar/mediastinal adenopathy Miliary findings Discrete linear opacity Discrete nodule(s) without calcification Volume loss or retraction Irregular thick pleural reaction Other (further describe in Remarks section below) **(4) Sputum Smears and Cultures Decision** No, not indicated Yes, indicated due to signs or symptoms of TB Yes, indicated due to chest X-ray suggestive of TB Yes, indicated due to known HIV infection or extrapulmonary TB Yes, indicated for end of treatment cultures **(5) Sputum Smears and Cultures Results** Sputum Smear Results Date specimen obtained (*mm-dd-yyyy*) Date smear result reported (*mm-dd-yyyy)* Positive Negative 1. 2. 3. Sputum Culture Results Date specimen obtained (*mm-dd-yyyy*) Date culture result reported (*mm-dd-yyyy)* Positive Negative NTM Contaminated 1. 2. 3. (6) TB Classification/Findings (Select only if

	X-ray was performed): No Class A or Class B TB Class A Pulmonary TB Disease Class B2 Pulmonary TB Class B, Other Chest Condition (non-TB) Class B1 Extra Pulmonary TB Class B, Latent TB Infection Class B1 Pulmonary TB Class B0 Pulmonary TB **(4) Remarks:** (Include any signs or symptoms of TB, additional tests and therapy given, with start and stop dates and any changes. If you did not perform IGRA, give the reason why an exception applies.) **[Page 8]** **B. Syphilis** **(1)** Serologic Test for Syphilis (Required for applicants 15 years of age and older) **(a)** Name of Screening Test **(b)** Date Screening Run (mm/dd/yyyy) **(c)** Screening Nonreactive (mm/dd/yyyy) Screening Reactive, Titer 1 **(d)** If Reactive, Name of Confirmatory Test **(e)** Date Confirmation Run (mm/dd/yyyy) **(f)** Confirmation Nonreactive Confirmation Reactive [new] **(2) Findings:** No Class A or Class B Syphilis Syphilis, Class A (untreated) Syphilis, Class B (treated in the last year) **(3) Remarks:** (Include any therapy given with doses and dates) Drug Dosage Start Date (mm/dd/yyyy) End Date (mm/dd/yyyy)	chest X-ray was performed): No Class A or Class B TB Class A Pulmonary TB Disease Class B0 Pulmonary TB Class B1 Pulmonary TB Class B1 Extrapulmonary TB Class B2 TB, Latent TB Infection Class B, Other Chest Condition (non-TB) **(7) Remarks:** (Include any signs or symptoms of TB, additional tests and therapy given, with start and stop dates and any changes. If you did not perform IGRA, give the reason why an exception applies.) **[Page 8]** **B. Syphilis** **(1)** Serologic Test for Syphilis (Required for applicants 18 to 44 years). All tests must be performed on the same blood sample. **(a)** Name of Nontreponemal Test **(b)** Date Nontreponemal Test Collected (mm/dd/yyyy) **(c)** Nontreponemal Test Nonreactive Date Reported (mm/dd/yyyy) Screening Reactive, Titer 1 **(d)** Name of Treponemal Test **(e)** Date Treponemal Test Reported (mm/dd/yyyy) **(f)** Treponemal Test Nonreactive Treponemal Test Reactive **(g)** If using reverse algorithm and treponemal test reactive but nontreponemal test nonreactive: Name of Repeat Treponemal Test (preferably one based on different antigens) **(h)** Date Repeat Treponemal Test Reported (mm/dd/yyyy) **(i)** Repeat Treponemal Test Nonreactive Repeat Treponemal Test Reactive **(2) Findings:** No Class A or Class B Syphilis Syphilis, Class A (untreated) Syphilis, Class B (treated in the last year) **(3) Remarks:** (Include stage of syphilis diagnosed [primary, secondary, early latent, late latent or latent of unknown duration, tertiary, neurosyphilis, congenital] and any therapy given with doses and dates of administration) Drug Dosage Start Date (mm/dd/yyyy) End Date (mm/dd/yyyy)

	C. Gonorrhea **(1)** Laboratory Test for Gonorrhea (Require for applicants 15 years of age and older) **(a)** Screening Test Name **(b)** Date Specimen Reported (mm/dd/yyyy) **(c)** Positive Negative **(2) Findings:** No Class A or Class B Gonorrhea Gonorrhea, Class A (untreated) Gonorrhea, Class B (treated in the last year) **(3) Remarks:** (Include any treatment given with doses and dates) Drug Dosage Start Date (mm/dd/yyyy) End Date (mm/dd/yyyy) **[Page 9]** **D. Other Class A/Class B Conditions for Communicable Diseases of Public Health Significance** **(1) Findings** **(a)** No Class A/B Condition **(b)** Hansen's Disease (leprosy, any classification) untreated, Class A Indeterminate, tuberculoid, borderline tuberculoid (paucibacillary). Mid-borderline, borderline lepromatous, lepromtous (multibacillary) **(c)** Hansen's Disease (leprosy, any classification) treated or partially treated, Class B Indeterminate, tuberculoid, borderline tuberculoid (paucibacillary). Mid-borderline, borderline lepromatous, lepromtous (multibacillary) **(2) Remarks:** (Include any therapy given and any counseling or referrals) If you need extra space to complete this section, use the space provided in **Part 11. Additional Information.** **2. Physical or Mental Disorders With Associated Harmful Behavior** Include here any physical or mental disorders with current associated harmful behavior or history of associated harmful behavior judged likely to recur. This category of physical or mental disorders includes any diagnosis of	**C. Gonorrhea** **(1)** Laboratory Test for Gonorrhea (Required for applicants 18 to 24 years of age) **(a)** Screening Nucleic Acid Amplification Test (NAAT) Name **(b)** Date Result Reported (mm/dd/yyyy) **(c)** Positive Negative **(2) Findings:** No Class A or Class B Gonorrhea Gonorrhea, Class A (untreated) Gonorrhea, Class B (treated in the last year) **(3) Remarks:** (Include any symptoms or treatment given with doses and dates of administration) Drug Dosage Start Date (mm/dd/yyyy) End Date (mm/dd/yyyy) **[Page 9]** **D. Other Class A/Class B Conditions for Communicable Diseases of Public Health Significance** **(1) Findings** **(a)** No Class A/B Condition **(b)** Hansen's Disease (leprosy, any classification) untreated, Class A Indeterminate, tuberculoid, borderline tuberculoid (paucibacillary). Mid-borderline, borderline lepromatous, lepromtous (multibacillary) **(c)** Hansen's Disease (leprosy, any classification) treated or partially treated, Class B Indeterminate, tuberculoid, borderline tuberculoid (paucibacillary). Mid-borderline, borderline lepromatous, lepromtous (multibacillary) **(2) Remarks:** (Include any therapy given and any counseling or referrals) If you need extra space to complete this section, use the space provided in **Part 11. Additional Information.** **2. Physical or Mental Disorders With Associated Harmful Behavior** Include here any physical or mental disorders with current associated harmful behavior or history of associated harmful behavior judged likely to recur. This category of physical or mental disorders includes any diagnosis of

	substance-related disorders that involve any substance that is not listed in Schedule I, II, III, IV, or V of section 202 of the Controlled Substances Act (for example, diagnosis of an alcohol-related disorder). Diagnose mental disorders according to the diagnostic criteria in the most recent edition of the Diagnostic and Statistical Manual (DSM) or another authoritative source, as determined by the director of the CDC. Diagnose physical disorders according to the diagnostic criteria in the most recent edition of the World Health Organization's Manual of the International Classification of Diseases, Injuries, and Causes of Death (ICD) or another authoritative source as determined by the director of the CDC. See the CDC's Technical Instructions for more information. **A. Findings:** **(1)** No Class A or B Physical or Mental Disorder **(2)** Current Physical/Mental Disorder with Associated Harmful Behavior, Class A **(3)** History of Physical/Mental Disorder with Associated Harmful Behavior Likely to Recur, Class A **(4)** Current Physical/Mental Disorder without Associated Harmful Behavior, Class B **(5)** History of Physical/Mental Disorder with Associated Harmful Behavior Unlikely to Recur, Class B **B. Remarks:** (Include diagnosis, likelihood of recurrence of the harmful behavior, therapy given, and any counseling or referrals. If you need extra space to complete this section, use the space provided in **Part 11. Additional Information.** **[Page 10]** **3. Drug Abuse/Drug Addiction** ***The U.S. Department of Health and Human Services (DHHS) sets the medical guidelines for determining drug abuse and drug addiction.*** The terms are defined at 42 CFR 34.2(h) and (i). Include here any diagnosis of drug abuse or drug addiction. "Drug abuse" is "current substance use disorder or substance-induced disorder, mild," **but only** with respect to substances listed in Schedule I, II, III, IV, or V of section 202 of the Controlled Substances Act. Make the diagnosis according to the diagnostic criteria in the most current edition of the DSM, or by another authoritative source as determined by the director of the	substance-use disorders that involve any substance that is not listed in Schedule I, II, III, IV, or V of section 202 of the Controlled Substances Act (for example, diagnosis of an alcohol-use disorder). Diagnose mental disorders according to the diagnostic criteria in the most recent edition of the Diagnostic and Statistical Manual (DSM) or another authoritative source, as determined by the director of the CDC. Diagnose physical disorders according to the diagnostic criteria in the most recent edition of the World Health Organization's Manual of the International Classification of Diseases, Injuries, and Causes of Death (ICD) or another authoritative source as determined by the director of the CDC. See the CDC's *Technical Instructions for Civil Surgeons* for more information. **A. Findings:** **(1)** No Class A or B Physical or Mental Disorder **(2)** Physical/Mental Disorder with Associated Harmful Behavior, Class A **(3)** Physical/Mental Disorder with a History of Associated Harmful Behavior Likely to Recur, Class A **(4)** Physical/Mental Disorder without Associated Harmful Behavior, Class B **(5)** Physical/Mental Disorder with a History of Associated Harmful Behavior Unlikely to Recur, Class B **B. Remarks:** (Include diagnosis, likelihood of recurrence of the harmful behavior, therapy given, and any counseling or referrals. If you need extra space to complete this section, use the space provided in **Part 11. Additional Information.** **[Page 10]** **3. Drug Abuse/Drug Addiction** ***The U.S. Department of Health and Human Services (DHHS) sets the medical guidelines for determining drug abuse and drug addiction.*** The terms are defined at 42 CFR 34.2(h) and (i). Include here any diagnosis of drug abuse or drug addiction. "Drug abuse or drug addiction" is "current substance use disorder mild, moderate or severe" **but only** with respect to substances listed in Schedule I, II, III, IV, or V of section 202 of the Controlled Substances Act. Make the diagnosis according to the diagnostic criteria in the most current edition of the DSM, or by another authoritative source as determined by

	CDC. "Drug addiction" is "current substance use disorder or substance-induced disorder, moderate or severe," **but only** with respect to substances listed in Schedule I, II, III, IV, or V of section 202 of the Controlled Substances Act. Make the diagnosis according to the diagnostic criteria in the most current edition of the DSM. You may also make a diagnosis of full remission, according to the diagnostic criteria in the most current edition of the DSM or another authoritative source as determined by the director of the CDC. See the CDC's Technical Instructions for more information. **A. Findings:** **(1)** No Class A or B Substance (Drug) Abuse/Addiction **(2)** Substance (Drug) **Abuse**, Listed in section 202 of the Controlled Substances Act, Class A **(3)** Substance (Drug) **Addiction**, Listed in section 202 of the Controlled Substances Act, Class A **(4)** Substance (Drug) **Abuse** in Full Remission, Listed in section 202 of the Controlled Substances Act, Class B **(5)** Substance (Drug) **Addiction** in Full Remission, Listed in section 202 of the Controlled Substances Act, Class B **B. Remarks**: **(**Include any therapy given, rehabilitation, counseling or referrals. If you need extra space to complete this section, use the space provided in **Part 11. Additional Information** **4. Other Medical Conditions** (List any other Class B conditions, such as hypertension or diabetes, and all required evaluation components as found in HHS's Technical Instructions for Medical Examinations of Aliens in the United States.) **…**	the director of the CDC. [deleted] You may also make a diagnosis of full remission, according to the diagnostic criteria in the most current edition of the DSM or another authoritative source as determined by the director of the CDC. See the CDC's *Technical Instructions for Civil Surgeons* for more information. **A. Findings:** **(1)** No Class A or B Substance (Drug) Abuse/Addiction **(2)** Substance (Drug) **Abuse or Addiction**, listed in section 202 of the Controlled Substances Act, Class A **[deleted]** **(3)** Substance (Drug) **Abuse** in Full Remission, listed in section 202 of the Controlled Substances Act, Class B **(4)** Substance (Drug) **Addiction** in Full Remission, listed in section 202 of the Controlled Substances Act, Class B **B. Remarks**: **(**Include any therapy given, rehabilitation, counseling or referrals. If you need extra space to complete this section, use the space provided in **Part 11. Additional Information** **4. Other Medical Conditions** (List any other Class B conditions, such as hypertension or diabetes, and all required evaluation components as found in *Technical Instructions for Civil Surgeons*.) **…**
Page 11, **Part 9. Referral Evaluation** (To be completed by the health department or other doctor preforming the referral evaluation)	**[Page 11]** **Part 9. Referral Evaluation** (To be completed by the health department or other doctor performing the referral evaluation.) The applicant identified on this Form I-693 was referred to me by the civil surgeon named in **Part 7.** of this Form I-693. I have provided appropriate evaluation/treatment, having made every reasonable effort to verify that the person	**[Page 11]** **Part 9. Referral Evaluation** (To be completed by the health department or other doctor performing the referral evaluation.) The applicant identified on this Form I-693 was referred to me by the civil surgeon named in **Part 7.** of this Form I-693. I have provided appropriate evaluation/treatment, having made every reasonable effort to verify that the person

	whom I have evaluated/treated is the person identified in **Part 1.** **1. Evaluating Physician or Health Department's Full Name** **A.** Family Name (Last Name) Given Name (First Name) Middle Name **B.** Health Department's Name …	whom I have evaluated/treated is the person identified in **Part 1.** **1. Evaluating Physician or Health Department's Full Name** **A.** Family Name (Last Name) Given Name (First Name) Middle Name (if applicable) **B.** Health Department's Name …
Pages 12-13, Part 10. Vaccination Record	**[Page 12]** **Part 10. Vaccination Record** **NOTE:** See *Technical Instructions* at **www.cdc.gov/immigrantrefugeehealth/exams/ti/civil/vaccination-civil-technical-instructions.html** for list of required vaccines, including COVID-19 vaccine guidance. Please make sure to mark every row. 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 applicants who only require a vaccination assessment:** Submit only this Part with **Parts 1. - 5.**, and **Part 7.** of Form I-693. (If you need an interpreter, complete **Part 3. Interpreter's Contact Information, Certification, and Signature.)** For more information, see Form I-693 Instructions, **Frequently Asked Questions.** **Vaccine History Transferred From A Written Record** Vaccine Specify Vaccine: DT DTaP DTP Specify Vaccine: Td Tdap Specify Vaccine: OPV IPV MMR (measles, mumps-rubella) or if monovalent or other combination of the vaccines are given, specify vaccines Hib	**[Page 12]** **Part 10. Vaccination Record** **NOTE:** See *Technical Instructions for Civil Surgeons* at **www.cdc.gov/immigrantrefugeehealth/exams/ti/civil/vaccination-civil-technical-instructions.html** for list of required vaccines, including COVID-19 vaccine guidance. Please make sure to mark every row. Reserve all comments for the Remarks section below. **For applicants who only require a vaccination assessment:** Submit only this Part with **Parts 1. - 5.**, and **Part 7.** of Form I-693. (If you need an interpreter, complete **Part 3. Interpreter's Contact Information, Certification, and Signature.)** For more information, see Form I-693 Instructions, **Frequently Asked Questions.** **Vaccine History Transferred From A Written Record** Vaccine Specify Vaccine: DT DTaP DTP Specify Vaccine: Td Tdap Specify Vaccine: OPV IPV MMR (measles, mumps-rubella) or if monovalent or other combination of the vaccines are given, specify vaccines Hib

	Hepatitis B Varicella Pneumococcal Influenza Rotavirus Hepatitis A Meningococcal COVID-19 (In "Remarks" section, write "COVID-19" and specify vaccine brand) Date Received (mm/dd/yyyy) Date Received (mm/dd/yyyy) Date Received (mm/dd/yyyy) Date Received (mm/dd/yyyy) **Vaccine Given** Date Given by Civil Surgeon (mm/dd/yyyy) **Complete Series** Mark an X if complete; write date of lab test if immune or "VH" if varicella history **Blanket Waiver(s) to be Requested from USCIS (Not Medically Appropriate)** Not Age-Appropriate Contraindication Insufficient Time Interval *See Below Table **NOTE: Give a copy to the applicant.** ***For Influenza vaccine**, check the box in this column only if vaccine is not medically appropriate because it is not flu season. ***For COVID-19 vaccine**, check the box in this column only if vaccine is not routinely available in the state where the civil surgeon practices according to the *Technical Instructions* blanket waivers for this vaccine. **[Page 13]** **Results:** Applicant completed vaccination requirements or may be eligible for blanket waivers as indicated above Applicant will request an individual waiver based on religious or moral convictions Applicant does not meet immunization requirements	Hepatitis B Varicella Pneumococcal Influenza Rotavirus Hepatitis A Meningococcal COVID-19 (In "Remarks" section, write "COVID-19" and specify vaccine brand) Date Received (mm/dd/yyyy) Date Received (mm/dd/yyyy) Date Received (mm/dd/yyyy) Date Received (mm/dd/yyyy) **Vaccine Given** Date Given by Civil Surgeon (mm/dd/yyyy) **Complete Series** Mark an X if complete; write date of lab test if immune or "VH" if varicella history **Blanket Waiver(s) to be Requested from USCIS (Not Medically Appropriate)** Not Age-Appropriate Contraindication Insufficient Time Interval *See Below Table **NOTE: Give a copy to the applicant.** ***For influenza vaccine**, check the box in this column only if vaccine is not available in the location where the civil surgeon practices. The civil surgeon is responsible for knowing local availability of the influenza vaccine. ***For COVID-19 vaccine**, check the box in this column only if vaccine is not routinely available in the location where the civil surgeon practices according to the *Technical Instructions for Civil Surgeons* blanket waivers for this vaccine. **[Page 13]** **Results:** Applicant completed vaccination requirements or may be eligible for blanket waivers as indicated above Applicant will request an individual waiver based on religious or moral convictions Applicant does not meet immunization requirements

	Remarks: (If needed, provide any comments, such as the reason for contraindication.) **FOR USCIS USE ONLY** **Remarks** (if any)	**Remarks:** (If needed, provide any comments, such as the reason for contraindication.) **FOR USCIS USE ONLY** **Remarks** (if any)
Page 14, **Part 11. Additional Information**	**[Page 14]** **Part 11. Additional Information** If you need extra space to provide any additional information within this form, 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 form or attach a separate sheet of paper. Type or print your name and A-Number (if any) at the top of each sheet; indicate the **Page Number**, **Part Number**, and **Item Number** to which your answer refers; and sign and date each sheet. **1.** Family Name (Last Name) [Auto-populated field] Given Name (First Name) [Auto-populated field] Middle Name [Auto-populated field] **2.** A-Number (if any) [Auto-populated field] **3. A.** Page Number **B.** Part Number **C.** Item Number **D.** [Fillable field] **4. A.** Page Number **B.** Part Number **C.** Item Number **D.** [Fillable field] **5. A.** Page Number **B.** Part Number **C.** Item Number **D.** [Fillable field] **6. A.** Page Number **B.** Part Number **C.** Item Number **D.** [Fillable field]	**[Page 14]** **Part 11. Additional Information** If you need extra space to provide any additional information within this form, 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 form or attach a separate sheet of paper. Type or print your name and A-Number (if any) at the top of each sheet; indicate the **Page Number**, **Part Number**, and **Item Number** to which your answer refers; and sign and date each sheet. **1.** Family Name (Last Name) [Auto-populated field] Given Name (First Name) [Auto-populated field] Middle Name (if applicable) [Auto-populated field] **2.** A-Number (if any) [Auto-populated field] **3. A.** Page Number **B.** Part Number **C.** Item Number **D.** [Fillable field] **4. A.** Page Number **B.** Part Number **C.** Item Number **D.** [Fillable field] **5. A.** Page Number **B.** Part Number **C.** Item Number **D.** [Fillable field] **6. A.** Page Number **B.** Part Number **C.** Item Number **D.** [Fillable field]