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 03/31/2022

► **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 *(USPS ZIP Code Lookup)*

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)
► **A-**

F. USCIS Online Account Number (if any)
►

Part 2. Applicant's Statement, Contact 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

NOTE: Select the box for either **Item A.** or **B.** in **Item Number 1.** If applicable, select the box for **Item Number 2.**

1. Applicant's Statement Regarding the Interpreter

A. ☐ I can read and understand English, and I have read and understand every question and instruction on this form and my answer to every question.

B. ☐ The interpreter named in **Part 3.** read to me every question and instruction on this form and my answer to every question in _____, a language in which I am fluent, and I understood everything.

Family Name (Last Name)	Given Name (First Name)	Middle Name	A-Number (if any)
			▶ A-

Part 2. Applicant's Statement, Contact Information, Certification, and Signature (continued)

2. Applicant's Statement Regarding the Preparer

☐ At my request, the preparer named in **Part 4.**, _____, prepared this application for me based only upon information I provided or authorized.

Applicant's Contact Information

Provide your daytime telephone number, mobile telephone number (if any), and email address (if any).

3. Applicant's Daytime Telephone Number

4. Applicant's Mobile Telephone Number (if any)

5. Applicant's Email Address (if any)

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 furthermore 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 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 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.

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 or fail to submit required documents listed in the Instructions, USCIS may deny your immigration benefit application.

Family Name (Last Name)	Given Name (First Name)	Middle Name	A-Number (if any)
			▶ A-

Part 3. Interpreter's Contact Information, Certification, and Signature

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

1. Interpreter's Family Name (Last Name)

Interpreter's Given Name (First Name)

2. Interpreter's Business or Organization Name (if any)

Interpreter's Mailing Address

3. Street Number and Name

Apt. Ste. Flr. Number

City or Town

State ZIP Code

Province

Postal Code

Country

Interpreter's Contact Information

4. Interpreter's Daytime Telephone Number

5. Interpreter's Mobile Telephone Number (if any)

6. Interpreter's Email Address (if any)

Interpreter's Certification

I certify, under penalty of perjury, that:

I am fluent in English and _____, which is the same language specified in **Part 2.**, **Item B.** in **Item Number 1.**, and I have read to this applicant in the identified language every question and instruction on this form and his or her answer to every question. The applicant informed me that he or she understands every instruction, question, and answer on the form, including the **Applicant's Certification**, and has verified the accuracy of every answer.

Interpreter's Signature

7. Interpreter's Signature

Date of Signature (mm/dd/yyyy)

Family Name (Last Name)	Given Name (First Name)	Middle Name	A-Number (if any)
			▶ A-

Part 4. Contact Information, Declaration, and Signature of the Person Preparing this Application, if Other Than the Applicant

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)

Preparer's Mailing Address

3. Street Number and Name

Apt. Ste. Flr. Number

City or Town

State

ZIP Code

Province

Postal Code

Country

Preparer's Contact Information

4. Preparer's Daytime Telephone Number

5. Preparer's Mobile Telephone Number (if any)

6. Preparer's Email Address (if any)

Preparer's Statement

7. **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.

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.

NOTE: 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.

Family Name (Last Name)	Given Name (First Name)	Middle Name	A-Number (if any)
			▶ A-

Part 4. Contact Information, Declaration, and Signature of the Person Preparing this Application, if Other Than the Applicant (continued)

Preparer's Certification

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 **Applicant's Certification**, 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.

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.

Part 5. Applicant's Identification Information (To be completed by the civil surgeon)

Please complete the following about the applicant:

1. Form of identification presented by applicant (for example, passport or driver's license)

2. Document Identification Number

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)

Family Name (Last Name)	Given Name (First Name)	Middle Name	A-Number (if any)
			▶ A-

Part 7. Civil Surgeon's Contact Information, 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

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

City or Town | State | ZIP Code

Mailing Address

4. Street Number and Name (PO Box) | Apt. Ste. Flr. | Number (if applicable)

City or Town | State | ZIP Code

Contact Information

5. Daytime Telephone Number

6. Mobile Telephone Number (if any)

7. Email Address (if any)

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.**;

Family Name (Last Name)	Given Name (First Name)	Middle Name	A-Number (if any)
			▶ A-

Part 7. Civil Surgeon's Contact Information, Certification, and Signature (continued)

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)

Family Name (Last Name)	Given Name (First Name)	Middle Name	A-Number (if any)
			▶ A-

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.)

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:

TB Classification/Findings (Select only if chest X-ray was performed):

☐ Infiltrate or consolidation
☐ Pleural effusion
☐ Discrete nodule(s) without calcification
☐ Reticular markings suggestive of fibrosis
☐ Hilar/mediastinal adenopathy
☐ Volume loss or retraction
☐ Cavitary lesion
☐ Miliary findings
☐ Irregular thick pleural reaction
☐ Nodule(s) or mass with poorly defined margins (*such as tuberculoma)*
☐ Discrete linear opacity
☐ 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

Family Name (Last Name)	Given Name (First Name)	Middle Name	A-Number (if any)
			▶ A-

Part 8. Civil Surgeon Worksheet (continued)

(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 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.)

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:

Family Name (Last Name)	Given Name (First Name)	Middle Name	A-Number (if any)
			▶ A-

Part 8. Civil Surgeon Worksheet (continued)

(d) Name of Treponemal Test

(e) Date Treponemal Test Reported (mm/dd/yyyy)

(f) ☐ Terponemal 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, congential] 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 (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)

Family Name (Last Name)	Given Name (First Name)	Middle Name	A-Number (if any)
			▶ A-

Part 8. Civil Surgeon Worksheet (continued)

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, lepromatous (multibacillary)

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

☐ Indeterminate, tuberculoid, borderline tuberculoid (paucibacillary)

☐ Mid-borderline, borderline lepromatous, lepromatous (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-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**.

Family Name (Last Name)	Given Name (First Name)	Middle Name	A-Number (if any)
			▶ A-

Part 8. Civil Surgeon Worksheet (continued)

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 the director of the CDC.

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

(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*.)

5. Required Referral to Health Department or Other Doctor (To be completed by civil surgeon, if a referral is medically required.)

A. Type or Print Name of Doctor or Health Department Receiving Required Referral

B. Address

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

City or Town | State | ZIP Code

C. Date of Referral (mm/dd/yyyy)

Family Name (Last Name)	Given Name (First Name)	Middle Name	A-Number (if any)
			▶ A-

Part 8. Civil Surgeon Worksheet (continued)

D. Remarks: (Include the name of medical condition and the reasons for referral. **If you need extra space to complete this section, use the space provided in Part 11. Additional Information**.

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 (if applicable)

B. Health Department 's Name

2. Address

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

City or Town | State | ZIP Code

3. Signature of Health Department Individual or Other Doctor Performing Referral Evaluation

Signature | Date Signed (mm/dd/yyyy)

4. Name of Medical Practice or Health Department

5. Daytime Telephone Number

NOTE: If you need extra space to complete this section, use the space provided in **Part 11. Additional Information**.

Family Name (Last Name)	Given Name (First Name)	Middle Name	A-Number (if any)
			▶ A-

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 Given**	**Complete Series**	**Blanket Waiver(s) to be Requested from USCIS (Not Medically Appropriate)**			
Vaccine	Date Received (mm/dd/yyyy)	Date Received (mm/dd/yyyy)	Date Received (mm/dd/yyyy)	Date Received (mm/dd/yyyy)	Date Given by Civil Surgeon (mm/dd/yyyy)	Mark an X if complete; write date of lab test if immune or "VH" if varicella history	Not Age - Appropriate	Contra-indication	Insufficient Time Interval	*See Below Table
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)							☐	☐	☐	☐

NOTE: Give a copy to the applicant.

Family Name (Last Name)	Given Name (First Name)	Middle Name	A-Number (if any)
			▶ A-

Part 10. Vaccination Record (continued)

***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.

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)

Part 11. Additional Information

If you (the applicant or the civil surgeon) need extra space to provide any additional information within this form use the space below. If you (the applicant or civil surgeon) 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 the applicant's 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) | Given Name (First Name) | Middle Name (if applicable)

2. A-Number (if any) ► **A-**

3. **A.** Page Number **B.** Part Number **C.** Item Number

D.

4. **A.** Page Number **B.** Part Number **C.** Item Number

D.

5. **A.** Page Number **B.** Part Number **C.** Item Number

D.

6. **A.** Page Number **B.** Part Number **C.** Item Number

D.