

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 07/31/2025

► 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 (USPS ZIP Code Lookup) Other Information A. Gender **B.** Date of Birth (mm/dd/yyyy) C. City/Town/Village of Birth Male Female D. Country of Birth **E.** Alien Registration Number (A-Number) (if any) **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. 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. 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.

Family Name (Last Name)	Given Name (First Name)	Middle Name	A-Number (if any)
			► A-
rt 2. Applicant's Statement	t, Contact Information,	Certification, and Si	gnature (continued)
plicant's Contact Informatio	on .		
Applicant's Daytime Telephone N	umber	4. Applicant's Mobile T	Celephone Number (if any)
, , , , , , , , , , , , , , , , , , ,			
Annlicant's Email Address (if any)		
apprount of the state of the st			
olicant's Certification			
	on from any and all of my rec	cords that USCIS may need	d to determine my eligibility for the
			•
• •		•	
1) I reviewed and provid	ed or authorized all of the info	ormation in my form;	
2) I understood all of the	information contained in, and	d submitted with, my form	; and
3) All of this information	n was complete, true, and corre	ect at the time of filing.	
t 1. of this form is complete, true, ired tests and procedures to be coved information or documents with medical examination may be revo	and correct. I understand the mpleted. If it is determined the regard to my medical exami	e purpose of this medical e hat I willfully misrepresen nation, I understand that a	examination, and I authorize the nted a material fact or provided false or any immigration benefit I derived from
olicant's Signature			
ΓE: Do not sign or date Form I-	693 until instructed to do so	by the civil surgeon.	
Applicant's Signature			Date of Signature (mm/dd/yyyy)
	•	_	not completely fill out this form
rt 3. Interpreter's Contact	Information, Certificat	ion, and Signature	
ride the following information abo	ut the interpreter, if you used o	one.	
erpreter's Full Name			
Interpreter's Family Name (Last N	(ame)	Interpreter's Given Na	me (First Name)
	Applicant's Contact Information Applicant's Daytime Telephone N Applicant's Email Address (if any plicant's Email Address (if any plicant's Certification and thorize the release of any information in the plicant and persons where necessary for the derstand that USCIS may require relature) and, at that time, if I am require and, at that time, if I am require plicant and persons where necessary for the properties of the standard provided and provided and provided and provided and provided and provided the standard penalty of perjury that the standard penalty of pen	Applicant's Daytime Telephone Number Applicant's Email Address (if any) Applicant's Certification thorize the release of any information from any and all of my recigiration benefit I seek. thermore authorize release of information contained in this form ites and persons where necessary for the administration and enfortestand that USCIS may require me to appear for an appointme ature) and, at that time, if I am required to provide biometrics, I 1) I reviewed and provided or authorized all of the information contained in, and 3) All of this information was complete, true, and correctify, under penalty of perjury that I am the person who is ident to this form is complete, true, and correct. I understand the inferd tests and procedures to be completed. If it is determined the dinformation or documents with regard to my medical examination may be revoked, that I may be removed formatical examination may be revoked, that I may be removed formation penalties. Policant's Signature TE: Do not sign or date Form I-693 until instructed to do so Applicant's Signature TE: TO ALL APPLICANTS AND CIVIL SURGEONS: If your ording to the instructions USCIS may deny your immigration berefit to the following information about the interpreter, if you used the following information about the interpreter, if you used the following information about the interpreter, if you used the following information about the interpreter, if you used the following information about the interpreter, if you used the following information about the interpreter, if you used the following information about the interpreter, if you used the following information about the interpreter, if you used the following information about the interpreter, if you used the following information about the interpreter, if you used the following information about the interpreter, if you used the following information about the interpreter, if you used the following information about the interpreter.	rt 2. Applicant's Statement, Contact Information, Certification, and Siplicant's Contact Information Applicant's Daytime Telephone Number Applicant's Email Address (if any) Applicant's Email Address (if any) Applicant's Certification Applicant's Certification Applicant's Certification Applicant's Certification Applicant's Certification Applicant's Certification Applicant's State of any information contained in this form, in supporting documents ices and persons where necessary for the administration and enforcement of U.S. immigration earth at USCIS may require me to appear for an appointment to take my biometrics (atture) and, at that time, if I am required to provide biometrics, I will be required to sign and I) 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 3) All of this information was complete, true, and correct at the time of filing. It if this form is complete, true, and correct. I understand the purpose of this medical interest to the information or documents with regard to my medical examination, I understand that a medical examination may be revoked, that I may be removed from the United States, and inal penalties. Policant's Signature The TO ALL APPLICANTS AND CIVIL SURGEONS: If you or the civil surgeon do not refund to the instructions USCIS may deny your immigration benefit. The TO ALL APPLICANTS AND CIVIL SURGEONS: If you or the civil surgeon do not refund to the instructions uscals may deny your immigration benefit.

Form I-693 Edition 07/19/22 Page 2 of 14

Family Name (Last Name) Given Name (Given Name (First Name)	rst Name) Middle Name		A-Number (if any)				
				► A-					
Part 3.	Interpreter's Contact	Information, Certificat	ion, and Signature	(continued	d)				
Interpr	eter's Mailing Address								
3. Stree	t Number and Name			Apt. Ste. I	Flr. Number				
City	or Town			State	ZIP Cod	<u>e</u>			
Prov	ince	Postal Code	Country						
Interpr	eter's Contact Informat	ion							
4. Inter	preter's Daytime Telephone N	Number	5. Interpreter's Mobi	le Telephon	e Number (if	any)			
6. Inter	preter's Email Address (if any	<i>i</i>)							
Interpr	eter's Certification								
I certify,	under penalty of perjury, that	:							
	nt in English and		, which is the sa		_				
		o this applicant in the identified plicant informed me that he or							
		fication, and has verified the a			,				
Interpr	eter's Signature								
7. Inter	preter's Signature			Da	te of Signatui	re (mm/do	d/yyyy)		
D / 4					(1 · A 1 ·	4.9	• 6		
	Contact Information, Than the Applicant	Declaration, and Signa	ture of the Person I	'reparing	this Appli	cation,	lÎ		
Provide tl	he following information abo	ut the preparer.							
Prepare	er's Full Name								
•	arer's Family Name (Last Na	me)	Preparer's Given Nar	ne (First Na	me)				
	•	·		,	,				
2. Prepa	arer's Business or Organization	on Name (if any)							

Form I-693 Edition 07/19/22 Page 3 of 14

		► A-
	Part 4. Contact Information, Declaration, and Signature of the Person Pr Other Than the Applicant (continued)	reparing this Application, if
Pr	Preparer's Mailing Address	
3.	3. Street Number and Name	Apt. Ste. Flr. Number
	City or Town	State ZIP Code
	Province Postal Code Country	
Pr	Preparer's Contact Information	
4.	4. Preparer's Daytime Telephone Number 5. Preparer's Mobile T	Celephone Number (if any)
6.	6. Preparer's Email Address (if any)	
Pr	Preparer's Statement	
7.	7. A. I am not an attorney or accredited representative but have prepared this application the applicant's consent.	on on behalf of the applicant and with
	B. I am an attorney or accredited representative and my representation of the application. extends does not extend beyond the preparation of this application.	ant in this case
	NOTE: If you are an attorney or accredited representative, you may need to submit a complet Appearance as Attorney or Accredited Representative, with this application.	ed Form G-28, Notice of Entry of
Pr	Preparer's Certification	
revi witl	By my signature, I certify, under penalty of perjury, that I prepared this application at the requereviewed this completed application and informed me that he or she understands all of the info with, his or her application, including the Applicant's Certification , and that all of this information that the applicant provided to me or authorized to me or authorize	rmation contained in, and submitted nation is complete, true, and correct. I
Pr	Preparer's Signature	
8.	8. Preparer's Signature	Date of Signature (mm/dd/yyyy)
	Parts 5 10. of this form must be completed by the civil su	irgeon.
Pa	Part 5. Applicant's Identification Information (To be completed by the civ	vil surgeon) (continued)
Plea	Please complete the following about the applicant:	
1.	1. Form of identification presented by applicant (for example, passport or driver's license)	
2.	2. Document Identification Number	

Given Name (First Name)

Middle Name

A-Number (if any)

Family Name (Last Name)

Form I-693 Edition 07/19/22 Page 4 of 14

				>	A-	
Pa	art 6. Summary of Medical Examination (To be	e comple	ted by the	civil surge	eon)	
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. C	ivil Surgeon	Workshee	t)	
	C. Class A Conditions (See Item Numbers 1 3. in	n Part 8. C	ivil Surgeon	workshee	t)	
2.	Date of First Examination (mm/dd/yyyy)					
3.	Dates of Follow-up Examinations, if required:					
	Date of Examination (mm/dd/yyyy) Date of Examina	tion (mm/c	dd/yyyy)	Date of Exa	mination	(mm/dd/yyyy)
Pa	art 7. Civil Surgeon's Contact Information, Ce	rtificatio	n, and Sig	gnature		
NO	OTE: Do not sign Form I-693 and do not have the applicant	sign in Pa	rt 2. until al	l health-rela	ted follow	-up requirements are met.
Ci	ivil Surgeon's Information					
1.	Family Name (Last Name) Give	en Name (F	First Name)		Middle	Name (if applicable)
2.	Name of Medical Practice, Facility, or Health Department					
Ph	hysical Address					
3.	Street Number and Name			Ap	t. Ste. Flr.	Number
	City or Town			Sta	te	ZIP Code
Ma	Tailing Address					
4.	Street Number and Name (PO Box)			Ap	t. Ste. Flr.	Number (if applicable)
	City or Town			Sta	te	ZIP Code
Co	ontact Information					
5.	Daytime Telephone Number	6.	Mobile Tel	lephone Nur	nber (if an	y)
7.	Email Address (if any)					

Given Name (First Name)

Middle Name

A-Number (if any)

Family Name (Last Name)

Form I-693 Edition 07/19/22 Page 5 of 14

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)

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.

Ci	ivil Surgeon's Signature
8.	Civil Surgeon's Signature Date of Signature (mm/dd/yyyy)
(E	lealth departments and military treatment facilities MUST place their official stamp or seal here)
	(official stamp or seal here)

Form I-693 Edition 07/19/22 Page 6 of 14

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 at www.cdc.gov/immigrantrefugeehealth/exams/ti/ civil/technical-instructions-civil-surgeons.html)

1.	Communicable	Disease of	Public	Health	Significance

ımu	unicable Disease of Public Health Significance
age	Derculosis (TB): An initial screening test, an interferon gamma release assay (IGRA), is required for all applicants 2 years of and older; for children under 2 years of age, see the <i>Technical Instructions</i> . The civil surgeon will perform further luation if needed (chest X-ray).
(1)	Interferon Gamma Release Assay (for acceptable IGRAs, consult the <i>Technical Instructions</i> and any updates posted on the CDC's website):
	Not administered (IGRA exception; please explain in Remarks section below)
	Select only one box.
	QuantiFERON T-Spot
	Date Blood Sample Drawn (mm/dd/yyyy) 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.)
(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.)
	TB Classification/Findings (Select only if chest X-ray was performed):
	No Class A or Class B TB Class B1 Extra Pulmonary TB
	Class A Pulmonary TB Disease Class B, Latent TB Infection
	Class B2 Pulmonary TB Class B1 Pulmonary TB
	Class B, Other Chest Condition (non-TB) Class B0 Pulmonary TB
	Class B, Other Chest Condition (non-1B)
(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.)
	Tult age eval (1) (2)

Form I-693 Edition 07/19/22 Page 7 of 14

Family Name (Last Name)	Given Name (First Name)	Middle Name	A-Number (if any)
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		N-
rt 8. C	Civil Surgeon Worksheet (continued)	
B. Syp	philis	
(1)	Serologic Test for Syphilis (Required for applicants 15 years of age a	nd 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	
(2)) Findings:	
	☐ No Class A or Class B Syphilis ☐ Syphilis, Class A (untreate	ed) Syphilis, Class B (treated in the last ye
(3)	Remarks: (Include any therapy given with doses and dates)	
	Denote D	22221
	Drug:	osage:
	Start Date (mm/dd/yyyy) End D	ate (mm/dd/yyyy)
	onorrhea	
(1)	Laboratory Test for Gonorrhea (Required for applicants 15 years of a	ge 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 (unt	reated)
(3)	Gonorrhea, Class B (treated in the last year) Pamerker (Include any treatment given with deceased dates)	
(3)	Remarks: (Include any treatment given with doses and dates)	

Form I-693 Edition 07/19/22 Page 8 of 14

End Date (mm/dd/yyyy)

Start Date (mm/dd/yyyy)

Family Name (Last Name)	Given Name (First Name)	Middle Name	A-Number (if any)				
			► A-				
art 8. Civil Surgeon Work	sheet (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 .
Ph	ysical or Mental Disorders With Associated Harmful Behavior
jud inv dia of t Dia Ma	lude here any physical or mental disorders with current associated harmful behavior or history of associated harmful behavior ged likely to recur. This category of physical or mental disorders includes any diagnosis of substance-related disorders that olve any substance that is not listed in Schedule I, II, III, IV, or V of section 202 of the Controlled Substances Act (for example, gnosis of an alcohol-related disorder). Diagnose mental disorders according to the diagnostic criteria in the most recent edition he Diagnostic and Statistical Manual (DSM) or another authoritative source, as determined by the director of the CDC. In agnose physical disorders according to the diagnostic criteria in the most recent edition of the World Health Organization's nual of the International Classification of Diseases, Injuries, and Causes of Death (ICD) or another authoritative source as the ermined 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
В.	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 .

2.

Form I-693 Edition 07/19/22 Page 9 of 14

	Family Name (Last Name)	Given Name (First Name)	Given Name (First Name) Middle Name					A-Number (if any)							
				► A-											
Par	t 8. Civil Surgeon Works	sheet (continued)													
. I	Drug Abuse/Drug Addiction														
	The U.S. Department of Health and diction. The terms are defined	and Human Services (DHHS) se at 42 CFR 34.2(h) and (i).	ts the medical guidelin	ies for deteri	mining d	lrug al	buse a	ınd dri	ug						
I	nclude here any diagnosis of dr	ug abuse or drug addiction.													
i	"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 CDC.														
s	0	I, III, IV, or V of section 202 of	ce use disorder or substance-induced disorder, moderate or severe," but only with respect to I, IV, or V of section 202 of the Controlled Substances Act. Make the diagnosis according rrent edition of the DSM.												
		of full remission, according to the termined by the director of the C							on.						
A	A. Findings:														
	(1) No Class A or B St	ubstance (Drug) Abuse/Addictio	n												
	(2) Substance (Drug) A	Abuse , Listed in section 202 of the	he Controlled Substanc	ces Act, Clas	ss A										
	(3) Substance (Drug) A	Addiction , Listed in section 202 of	of the Controlled Substa	ances Act, Cl	ass A										
	(4) Substance (Drug) A	Abuse in Full Remission, Listed	in section 202 of the C	Controlled Su	ibstances	s Act,	Class	В							
	(5) Substance (Drug) A														

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.)

B. Remarks: (Include any therapy given, rehabilitation, counseling or referrals. If you need extra space to complete this

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

R Address

B. Address
Street Number and Name

section, use the space provided in Part 11. Additional Information.

Apt. Ste. Flr. Number

State ZIP Code

City or Town State ZIP Code

Form I-693 Edition 07/19/22 Page 10 of 14

Г	Family Name (Last Name)	Given Name (First Name)			A-Number (II any)
				► A-	
rt	8. Civil Surgeon Worksl	neet (continued)			
C.	Date of Referral (mm/dd/yy	yy)_			
D.	Remarks: (Include the name section, use the space provide			you need extra	space to complete this
art	9. Referral Evaluation (To be completed by the	health department o	or other docto	or performing the
	ral evaluation)	1 ,	1		
err	,	. ,	•	in Part 7 , of th	is Form I-693 I have
ferr e app	plicant identified on this Form led appropriate evaluation/treatm	1-693 was referred to me by the theorem to the second seco	he civil surgeon named		
ferr e app	plicant identified on this Form	1-693 was referred to me by the theorem to the second seco	he civil surgeon named		
e appovide ated	plicant identified on this Form led appropriate evaluation/treatm is the person identified in Part	1-693 was referred to me by the nent, having made every reason. 1. Department's Full Name	he civil surgeon named onable effort to verify the	hat the person v	vhom I have evaluated/
ferre appovide ated	plicant identified on this Form led appropriate evaluation/treatm is the person identified in Part	1-693 was referred to me by the nent, having made every reason. 1. Department's Full Name	he civil surgeon named		vhom I have evaluated/
e appovide ated Ev. A.	plicant identified on this Form led appropriate evaluation/treatm is the person identified in Part valuating Physician or Health Family Name (Last Name)	1-693 was referred to me by the nent, having made every reason. 1. Department's Full Name	he civil surgeon named onable effort to verify the	hat the person v	vhom I have evaluated/
e appovide ated Ev. A.	plicant identified on this Form led appropriate evaluation/treatm is the person identified in Part	1-693 was referred to me by the nent, having made every reason. 1. Department's Full Name	he civil surgeon named onable effort to verify the	hat the person v	vhom I have evaluated/
ferre apposite and a second se	plicant identified on this Form led appropriate evaluation/treatm is the person identified in Part valuating Physician or Health Family Name (Last Name) Health Department 's Name	1-693 was referred to me by the nent, having made every reason. 1. Department's Full Name	he civil surgeon named onable effort to verify the	hat the person v	vhom I have evaluated/
ferr e appovide ated Ev A.	plicant identified on this Form led appropriate evaluation/treatm is the person identified in Part valuating Physician or Health Family Name (Last Name) Health Department 's Name	1-693 was referred to me by the nent, having made every reason. 1. Department's Full Name	he civil surgeon named onable effort to verify the	Middle	vhom I have evaluated/
ferr e appovide ated Ev A.	plicant identified on this Form led appropriate evaluation/treatm is the person identified in Part valuating Physician or Health Family Name (Last Name) Health Department 's Name	1-693 was referred to me by the nent, having made every reason. 1. Department's Full Name	he civil surgeon named onable effort to verify the	hat the person v	vhom I have evaluated/
ferr e appointed Ev A. B.	plicant identified on this Form led appropriate evaluation/treatm is the person identified in Part valuating Physician or Health Family Name (Last Name) Health Department 's Name ddress reet Number and Name	1-693 was referred to me by the nent, having made every reason. 1. Department's Full Name	he civil surgeon named onable effort to verify the	Apt. Ste. Fl	r. Number
ferr e appointed Ev A. B.	plicant identified on this Form led appropriate evaluation/treatm is the person identified in Part valuating Physician or Health Family Name (Last Name) Health Department 's Name	1-693 was referred to me by the nent, having made every reason. 1. Department's Full Name	he civil surgeon named onable effort to verify the	Middle	vhom I have evaluated/
Everage approvided the A. B. Add Stu	plicant identified on this Form led appropriate evaluation/treatm is the person identified in Part valuating Physician or Health Family Name (Last Name) Health Department 's Name ddress reet Number and Name	I-693 was referred to me by the nent, having made every reason 1. Department's Full Name Given Name	he civil surgeon named onable effort to verify the me (First Name)	Apt. Ste. FI	r. Number
ferr e appointed Ev A. B. Cit	plicant identified on this Form led appropriate evaluation/treatm is the person identified in Part valuating Physician or Health Family Name (Last Name) Health Department 's Name ddress reet Number and Name tty or Town gnature of Health Department	I-693 was referred to me by the nent, having made every reason 1. Department's Full Name Given Name	he civil surgeon named onable effort to verify the me (First Name)	Apt. Ste. Fl State State	r. Number ZIP Code
ferr e appovide ated Ev A. B. Cit	plicant identified on this Form led appropriate evaluation/treatm is the person identified in Part valuating Physician or Health Family Name (Last Name) Health Department 's Name ddress reet Number and Name	I-693 was referred to me by the nent, having made every reason 1. Department's Full Name Given Name	he civil surgeon named onable effort to verify the me (First Name)	Apt. Ste. Fl State State	r. Number
ferr e appovide ated Ev A. B.	plicant identified on this Form led appropriate evaluation/treatm is the person identified in Part valuating Physician or Health Family Name (Last Name) Health Department 's Name ddress reet Number and Name tty or Town gnature of Health Department	t Individual or Other Docto	he civil surgeon named onable effort to verify the me (First Name)	Apt. Ste. Fl State State Date	r. Number ZIP Code

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

Form I-693 Edition 07/19/22 Page 11 of 14

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

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.**

Information, Certification, and Signature.) For more information, see Form 1-693 Instructions, Frequently Asked Questions.										
Vaccine	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			Insufficient Time Interval	*See Below Table
Specify Vaccine: DT DTaP DTP										
Specify Vaccine: Td Tdap										
Specify Vaccine:										
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)	to the applicant									

NOTE: Give a copy to the applicant.

Form I-693 Edition 07/19/22 Page 12 of 14

^{*}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.

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

Part 10. Vaccination Record (continued)	
1 art 10. Vaccination Record (continued)	
Results:	FOR USCIS USE ONLY
Applicant completed vaccination requirements or may be eligible for blanket waivers as indicated above	Remarks (if any)
☐ 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.)	

Form I-693 Edition 07/19/22 Page 13 of 14

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Part I		Additiona	ıl In	tarma	tion
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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.

•	Fan	nily Name (Last I	Name)	G	iven Name (First Name)	Middle Name
•	A-N	Number (if any)	► A	-			
•	A.	Page Number	В.	Part Number	C.	Item Number	
	D.						
•	Α.	Page Number	В.	Part Number	C.	Item Number	
	D.						
	Α.	Page Number	В.	Part Number	C.	Item Number	
	D.						
•	A.	Page Number	В.	Part Number	C.	Item Number	
	D.						

Form I-693 Edition 07/19/22 Page 14 of 14