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)

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.

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.

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.

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)

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 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 law.

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 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.

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.

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

Provide the following information about the interpreter, if you used one.

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)

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

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

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)

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.

Preparer's Full Name

1. Preparer's Family Name (Last Name)

Preparer's Given Name (First Name)

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

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 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.

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

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) (continued)

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

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

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)

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): **Snider** | Given Name (First Name): **Gregory** | Middle Name (if applicable): **Thomas**

2. Name of Medical Practice, Facility, or Health Department: **Redpoint Medical, PSC (CSID# 104038)**

Physical Address

3. Street Number and Name: **128 Southland Drive** | Apt. ☐ Ste. ☒ Flr. ☐ Number: **110**

   City or Town: **Lexington** | State: **KY** | ZIP Code: **40503**

Mailing Address

4. Street Number and Name (PO Box): **128 Southland Drive** | Apt. ☐ Ste. ☒ Flr. ☐ Number (if applicable): **110**

   City or Town: **Lexington** | State: **KY** | ZIP Code: **40503**

Contact Information

5. Daytime Telephone Number: **8592231963**

6. Mobile Telephone Number (if any):

7. Email Address (if any): **snidermd@redpointmedical.net**

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.

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 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 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.

***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)

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

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.