Report of Immigration Medical Examination and Vaccination Record

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-693
OMB No. 1615-0033
Expires 03/31/2025

► **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 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)
► **A-**

F. USCIS Online Account Number (if any)
►

4. Immigration Medical Examination Requirement

A. ☐ I am eligible for completion of the vaccination record portion only, because I previously completed an overseas immigration medical examination, signed by a panel physician (refugee or derivative asylee adjustment of status applicants under Immigration and Nationality Act (INA) section 209 and K nonimmigrant visa holders applying for adjustment of status).

NOTE: If you selected this box for Item A. in Item Number 4., you, the applicant, and the civil surgeon are responsible for completing Parts 1. - 5., Part 7., and Part 10.

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

Applicant's Contact Information

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

1. Applicant's Daytime Telephone Number

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

3. Applicant's Email Address (if any)

Applicant's Certification and Signature

I certify, under penalty of perjury, that I provided or authorized all of the responses and information contained in and submitted with my application, I read and understand or, if interpreted to me in a language in which I am fluent by the interpreter listed in **Part 3.**, understood, all of the responses and information contained in, and submitted with, my form, and that all of the responses and the information are 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. Furthermore, I authorize the release of any information from any and all of my records that USCIS may need to determine my eligibility for an immigration request and to other entities and persons where necessary for the administration and enforcement of U.S. immigration law.

NOTE: Do not sign or date Form I-693 until instructed to do so by the civil surgeon.

4. Applicant's Signature

Date of Signature (mm/dd/yyyy)

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

Interpreter's Full Name

1. Interpreter's Family Name (Last Name)

Interpreter's Given Name (First Name)

2. Interpreter's Business or Organization Name

Interpreter's Contact Information

3. Interpreter's Daytime Telephone Number

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

5. Interpreter's Email Address (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 Certification and Signature

I certify, under penalty of perjury, that I am fluent in English and [ ], and I have interpreted every question on the application and Instructions and interpreted the applicant's answers to the questions in that language, and the applicant informed me that they understood every instruction, question, and answer on the application.

6. 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

Preparer's Full Name

1. Preparer's Family Name (Last Name)

Preparer's Given Name (First Name)

2. Preparer's Business or Organization Name

Preparer's Contact Information

3. Preparer's Daytime Telephone Number

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

5. Preparer's Email Address (if any)

Preparer's Certification and Signature

I certify, under penalty of perjury, that I prepared this application for the applicant at their request and with express consent and that all of the responses and information contained in and submitted with the application are complete, true, and correct and reflects only information provided by the applicant. The applicant reviewed the responses and information and informed me that they understand the responses and information in or submitted with the application.

6. 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

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 (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)

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

NOTE: Do not sign Form I-693 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

Civil Surgeon Identification Number (CSID) (unless performing the examination under a health department or military blanket designation): 104038

2. Name of Medical Practice, Facility, or Health Department: Redpoint Medical, PSC

Physical Address

3. Street Number and Name: 128 Southland Drive Suite #110 | Apt. Ste. Flr. Number:

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

Mailing Address

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

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 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)

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 a list of required vaccines, and **https://www.cdc.gov/immigrantrefugeehealth/civil-surgeons/covid-19-technical-instructions.html** for COVID-19 specific 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 "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.)

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Remarks (if any)