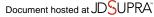
Examination and Vaccination Record

START HERE - Please type or print in (CAPITAL letters (Use black ink)				
Part 1. Information about you (7	The person requesting a medical ex	camination or vac	ccinations must complete this part)		
Family Name (Last Name)	Given Name (First Name)		Full Middle Name		
Home Address: Street Number and N	Vame		Apt. Number Gender:		
			Male Female		
City	State	Zip Code	Phone # (Include Area Code) no dashes or ()		
			There is a measure of the		
Date of Birth (mm/dd/yyyy) Place of Birth	(City/Town/Village) Country of Birth	n A-num	ber (if any) U.S. Social Security # (if any)		
Applicant's Certification					
this medical exam, and I authorize the requi	ired tests and procedures to be complet numents with regard to my medical exa- be removed from the United States, and	ed. If it is determing m, I understand that I that I may be subj	est of my knowledge. I understand the purpose of ned that I willfully misrepresented a material fact at any immigration benefit I derived from this ject to civil or criminal penalties. Date (mm/dd/yyyy)		
Part 2. Medical examination (The	civil surgeon completes this part)				
1. Examination Date of First Examination Summary of Overall Findings: No Class A or Class B Condition	Date(s) of Follow-up Examination(s Date of Exam D Class A Conditions (see 2 thr	ate of Exam	Date of Exam Class B Conditions (see 2 through 6 below)		
2. Communicable Diseases of Public He	ealth Significance				
	equired for applicants 2 years of age a //www.cdc.gov/ncidod/dq/civil.htm.)	nd older: for childr	ren under 2 years of age, see pp. 11-12 of		
Date TST Applied	Date TST Read		Size of Reaction (mm)		
	Y for TST reactions of ≥ 5 mm or if specion (e.g., HIV). Attach copy of X-Ray		on criteria met, or for an applicant with TB		
Date Chest X-Ray	Date Chest X-Ray		Results		
Taken	Read		Normal		
			Abnormal (Describe results in remarks.)		
Findings:					
No Class A or Class B TB☐ Class A Pulmonary TB Disease	Class B1 Pulmonary TB Class B1 Extra Pulmonary TB		ulmonary TB Class B, Other Chest Condition (non-TB)		
Remarks: (Include any signs or sy	mptoms of TB, additional tests, and the	erapy given, with s	stop and start dates and any changes.)		

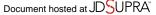


Part 2. Medical Examination	1 (Continued)		
B. Syphilis			
Serologic Test for Syphil	is (Required for applicants 15	years and older)	
Date Screening Run		Screening Nonreactive	
		Screening Reactive, Titer 1:	
If Reactive, Date Confirm	nation Run	Confirmation Nonreactive	
		Confirmation Reactive	
Findings:		_	
No Class A or Class B Syphilis	Syphilis, Class A (untreated)	Syphilis, Class B (with residual deficit, treated in the past year)	
Remarks: (Include any thera	py given with doses and dates.	.)	
C. HIV/AIDS Serologic Test for HIV A Date Screening Run	ntibody (Required for applica		Confirmation Negative
Date Screening Run	Screening Negat	Date Confirmation Run	Confirmation Positive
	Screening Positi		
Findings: No Class A HIV Remarks: (Include any signs	Screening Indete	erminate n, therapy given, and any counseling, or referrals	;.)
	itions for Communicable Dis	seases of Public Health Significance	
Findings:		A □ □ □ □ □ □	
Chancroid, Class A	Gonorrhea, Class		Leprosy, Infectious), Class A Leprosy, Noninfectious), Class B
Granuloma Inguinale, Cl			Leprosy, Nonlinectious), Class B
Remarks: (Include any thera	apy given and any counseling,	or referrals.)	
	7ith Associated Harmful Behavi th Associated Harmful Behavi thout Associated Harmful Beh	ior, Class A	
Remarks: (Include diagnosis	s, with likelihood of harmful be	ehavior to recur, therapy given, and any counsel	ing, or referrals.)
4. Drug Abuse/Drug Addiction			
	in Section 202 of Controlled S		
		lled Substance Act, But With Associated Harmfu	ıl Behavior, Class A
Prior Substance (Drug) Use in			
Remarks: (Include any thera	py given, rehabilitation, couns	seling, or referrals.)	



5. Vaccinations (See Technical Instructions at http://www.cdc.gov/ncidod/dq/civil.htm for list of required vaccines.)

Vaccine History Transferred From a Written Record		Vaccine Given	Completed Series	Waiver(s) to Be Requested From USCIS					
				Date Given	Mark an X if completed; write	Blanket			
	Date	Date	Date	by Civil	date of lab test if	Not Medically Appropriate			
Vaccine	Received mm/dd/yyyy	Received mm/dd/yyyy	Received mm/dd/yyyy	Surgeon mm/dd/yyyy	immune or "VH" if varicella history	Not Age Appropriate	Contra- indication	Insufficient Time Interval	Not Flu Season
Specify DT DT DTP DTP DTP DTP DTP DTP DTP DTP D									
Specify Td Tdap Tdap									
Specify OPV D									
MMR (Measles Mumps-Rubella) or if monovalent or other combination of the vaccines are given, specify vaccine(s):									
Hib									
Hepatitis B									
Varicella									
Pneumococcal									
Influenza									
Rotavirus									
Hepatitis A									
Meningococcal									
Human Papillomavirus									
Zoster									
Give Copy to Applicant Results: Applicant may be eligible for blanket waiver(s) as indicated above. Applicant will request an individual waiver based on religious or moral convictions. Vaccine history complete for each vaccine, all requirements met. Applicant does not meet immunization requirements.				A-number (if any) Name (Type or print your name)					



Part 2. Medical examination (Continued)	
6. List other medical conditions, Class B other (e.g. hypertension, diab	petes)
Part 3. Referral to health department or other doctor/fac	cility (To be completed by Civil Surgeon, if referral was made)
Type or Print Name of Doctor or Health Department	Date of Referral (mm/dd/yyyy)
Address: (Street Number and Name, City, State and Zip Code)	Daytime Phone # (Include Area Code) no dashes or ()
Remarks: (Include name of medical condition and reasons for referral.)	
Part 4. To Be Completed by Physician or Health Departs	ment Performing Referral Evaluation
The applicant identified on this form was referred to me by the civi evaluation/treatment.	l surgeon named in Part 5 of this form. I have provided appropriate
Type or Print Full Name of Evaluating Physician or Health Departme	ent Signature
Address: (Street Number and Name, City, State and Zip Code)	Date (mm/dd/yyyy)
Name of Medical Practice or Health Department	Daytime Phone # (Include Area Code) no dashes or ()
Remarks: (Attach a separate sheet of paper, if needed.)	

Part 5. Civil Surgeon's Certification (Do not sign form or have the applicant sign in Part 1 until all health follow-up requirements have been met.)

I certify under penalty of perjury under United States law that: I am a civil surgeon in current status designated to examine applicants seeking certain immigration benefits in the United States; I have a currently valid and unrestricted license to practice medicine in the state where I am performing medical examinations; I performed this examination of the person identified in **Part 1** of this Form I-693, after having made every reasonable effort to verify that person whom I examined is the person identified in **Part 1**; that I performed the examination in accordance with the Centers for Disease Control and Prevention's *Technical Instructions*, and all supplemental information or updates provided to me; and that all information provided by me on this form is true and correct to the best of my information, knowledge, and belief.

Address (Street Number and Name, City, State and Zip Code)		Date (mm/dd/yyyy)		
Daytime Phone # (Include Area Code) r	no dashes or ()	E-Mail Address		
Part 6. Health department ide refugee, place a stamp or		completed by State or local h	nealth department on behalf of a	
Type or Print Name			(Place State or local health department stamp/seal below.)	
Signature				
Date (mm/dd/yyyy)	Daytime Phone # (Include	e Area Code) no dashes or ()		