ALL parts of this form, except the "APPLICANT ATTESTATION" and "INTERPRETER'S CERTIFICATION" must be certified by a licensed medical professional as provided in the instructions for Form N-648. Before certifying this form, the medical professional must conduct an in-person examination of the applicant. (See instructions for Form N-648 for additional information which is also located in the "FORMS" section at <a href="https://www.uscis.gov">www.uscis.gov</a>.)

## **Reminder About Eligibility Requirements**

This form is intended for an applicant who seeks an exception to the English and/or civics requirements due to a physical or developmental disability or mental impairment that has lasted, or is expected to last, 12 months or more. An applicant who with reasonable accommodations provided under the Rehabilitation Act of 1973 can satisfy the English and civics requirements does not need to submit this form. Reasonable accommodations include, but are not limited to, sign language interpreters, extended time for testing, and off-site testing.

## Completing and Certifying This Form

All questions or items must be answered fully and accurately. Responses should utilize common terminology, without abbreviations, that a person without medical training can understand. U.S. Citizenship and Immigration Services (USCIS) recommends that the certifying medical professional use the electronic Form N-648 located in the "FORMS" section <a href="www.uscis.gov">www.uscis.gov</a>. If the medical professional completes the form by hand, then responses must be legible and appear in black ink.

Type or print clearly in black ink.

Part 1. APPLICANT INFORMATION					USCIS USE ONLY	
I certify that I have examined:						This N-648 is:
Last Name First Name Midd		Middle N	Middle Name USCI. A-		IS A-Number	☐ Sufficient ☐ Insufficient ☐ Continued/RFE
Address (Street Number and Name)  U.S. Social Security Number					Reviewer	
City		Stat	State or Province		Zip Code or Postal Code	Location & Date
Telephone Number	E-Mail Address (if any)		Date of Birth		Gender  Male Female	

## Part 2. MEDICAL PROFESSIONAL INFORMATION

Type or print clearly in black ink. If you need more space to complete an answer, use a separate sheet of paper. Type or print the applicant's name and Alien Registration Number (A-Number), at the top of each sheet of paper and indicate the part and number of the item to which the answer refers. You must sign and date each continuation sheet. You must answer and complete each question since USCIS will not accept an incomplete Form N-648. You may, but are not required to, attach to this completed form supportive medical diagnostic reports or records regarding the applicant.

**NOTE:** Only medical doctors, doctors of osteopathy, or clinical psychologists licensed to practice in the United States (including the U.S. territories of Guam, Puerto Rico, and the Virgin Islands) are authorized to certify the form. While staff of the medical practice associated with the medical professional certifying the form may assist in its completion, the medical professional is responsible for the accuracy of the form's content.

Last Name	First Name		Middle Name		
Business Address (Street Number and Name)	City	State or Province	Zip Code or Postal Code	Telephone Number	
License Number	Licensing State E-Mail Address (i		if any)		
I. Currently licensed as a (Check all that apply):   Medical Doctor Doctor of Osteopathy Clinical Psychologist					
2. Medical practice type:					

A	Applicant's Name		USCIS A-Number
			A-
P	art 3. INFORMAT	ION ABOUT DISABILITY and/or IMPAIRMENT(S)	
	and/or civics requirem Services (HHS). This is	ignosis of the applicant's disability and/or impairment, that form the ents. If applicable, please provide the relevant medical code as acconcludes the Diagnostic and Statistical Manual of Mental Disorders cample, DSM-V 318.1 Intellectual Disability (Severe) or 2015/16 ICI	epted by the Department of Health and Human (DSM) and the International Classification of
•		otion of the disability and/or impairments, for example, Intellectual tual disability, developmental delays, and other problems.	Disability (Severe) is a genetic disorder that
· ·		I the applicant regarding the conditions listed in number 1.	
	Date (mm/dd/yyyy)	Location (if different from business address on Page 1; otherwise type or pr	rint "same as business address")
•	Date you last examined  Date (mm/dd/yyyy)	the applicant regarding the conditions listed in number 1, if different Location (if different from business address on Page 1; otherwise type or produced to the conditions of the conditions listed in number 1, if different type or produced to the conditions of the conditions of the conditions listed in number 1, if different type or produced type of the conditions listed in number 1, if different type or produced type or produ	
j <b>.</b>	Yes (If "Yes," indic	ofessional regularly treating this applicant for the conditions listed cate duration of treatment.)  Years Months  de the name of the applicant's regularly treating medical professional on ad of the regularly treating medical professional.)	

Appl	icant's Name			USCIS A-Number A-		
Name	of Regularly Treating Medical Profession	al and Address				
	Name	First Name		Middle Name	Middle Name	
Business Address (Street Number and Name)		City State or Province		Zip Code or Postal Code	Telephone Number	
Expla	nation					
	Yes (If "Yes," continue to complete this fo No (If "No," the applicant is not eligible fo the "Medical Professional's Certification the applicant's disability and/or impairment Yes (If "Yes," the applicant is not eligible the "Medical Professional's Certification No (If "No," continue to complete this form	or this exception and you need non.")  Into the result of the applicant's for this exception and you need ion.")	ot complete the rea	mainder of the questions.		
8. W	8. What caused this applicant's medical disability and/or impairments listed in number 1, if known?					
_						
_						
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_						
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Α	applicant's Name	USCIS A-Number A-			
9.	hat clinical methods did you use to diagnose the applicant's medical disability and/or impairments listed in number 1?				
10.	. Clearly describe how the applicant's disability and/or impairments affect his or her ability to do of English and/or civics.	emonstrate knowledge and understanding			
11.	In your professional medical opinion, does the applicant's disability or impairments prevent his following requirements? (Check all that apply. If none applies, the applicant is not eligible for this of the ability to:				
	Read English				
	☐ Write English				
	☐ Speak English				
	Answer questions regarding United States history and civics, even in a language the applicant un	derstands.			

Applicant's Name		USCIS A-Number A-
12. Was an interpreter used during your examination of the applicant	?	
Yes (If "Yes," the interpreter must complete the "Interpreter Cert	ification" section.)	
□ No		
Additional Comments (Optional)		
MEDICAL PROFESSIO	NAL' S CERTIFICATI	ON
Complete the following if an interpreter was not used during your examinations that form the basis of this Form N-648.	ation of the applicant between	the applicant and medical professional
I am fluent in English and, the lar my examinations of this applicant.	iguage spoken by this patient.	Therefore, an interpreter was not used during
All medical professionals <b>must</b> complete the certification below.		
I certify that this applicant's identity has been verified through the fidentity document:	ollowing United States or Sta	te government-issued photographic
Permanent Resident Card	State ID Number:	
Other Identification (Indicate type and ID Number):		
I certify, under penalty of perjury under the laws of the United States of with it are all true and correct. I will furnish relevant medical records to I am aware that the knowing placement of false information on Form N-including under 18 U.S.C. section 1546, civil penalties under 8 U.S.C. seand civil license suspension or revocation by the appropriate authorities.	USCIS, if requested to do so b 648 and related documents magertion 1324c and Immigration a	by USCIS, based on the applicant's consent. y also subject me to criminal penalties
Licensed Medical Professional Signature		Date (mm/dd/yyyy)

Applicant's Name	USCIS A-Number	USCIS A-Number				
			A-			
I	NTERPRET	ER'S CERTIFICATION				
An interpreter must complete, and certify, the section below if an interpreter translated communications between the applicant and medical professional on the day of the examination that formed the basis of this Form N-648.						
Interpreter Information						
Last Name	First Name	Middle Name				
Address (Street Number and Name)		City	State or Province	Zip Code or Postal Code		
		I				
Was a phone interpreter used?						
Yes (If "Yes", the interpreter is not require	ed to complete the	e information below )				
	-					
☐ No (If "No", the interpreter is required to	complete the info	ormation below.)				
Interpreter Certification						
I am fluent as the interpreter, I certify that I am fl				<u> </u>		
I further certify that I have accurately and comple	etely translated all	l communications between the me	edical professional and	the applicant that		
occurred on	, the dates of the	examinations that form the basis of	of this certification.			
Interpreter Signature	Interpreter Signature Date (mm/dd/yyyy)					
APPLICANT (PATI	ENT) ATTE	STATION/RELEASE OF	INFORMATION			
I,(Applicant's Name)		, authorize	octor doctor of octoorath	y, or clinical psychologist)		
	. 11 1					
to release to U.S. Citizenship and Immigration Se						
purpose of applying for an exception from the English language and U.S. civics requirements for naturalization. I certify under penalty of perjury, pursuant to 28 U.S.C. section 1746, that the information I provided to the medical professional is true and correct. I am aware that the knowing						
placement of false information on Form N-648 and related documents may also subject me to civil penalties under 8 U.S.C. section 1324c and						
INA section 274C. I understand that if this form is not completely filled out or if I fail to submit any required documentation, I may not be found						
eligible for the requested disability exception.						
Applicant or Applicant's Authorized Represen	tative Signature	<u>,</u>	Date (mm/dd/y	vvvv)		
A THE RESIDENCE OF THE PROPERTY OF THE PROPERT			Dute (mm/dd/)	3337		
<b>–</b>						