Application for Civil Surgeon Designation

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

USCIS
Form I-910
OMB No. 1615-0114
Expires 05/31/2020

For USCIS Use Only	Initial Receipt	Barcode	Action Block
	Resubmitted		
Received		Remarks	
Sent		CSID Number	

To be completed by an attorney or accredited representative (if any).	☐ Select this box if Form G-28 is attached to represent the applicant.	Attorney State Bar Number (if applicable)	Attorney or Accredited Representative USCIS Online Account Number (if any)

► **START HERE - Type or print in black ink.**

Part 1. Information About You (The Applicant)

1.a. Have you ever been designated as a civil surgeon?

☐ Yes ☐ No

If you answered "Yes" to **Item Number 1.a.**, provide the following information.

1.b. Period of Designation (mm/dd/yyyy)
From _____ To _____

1.c. U.S. Citizenship and Immigration Services (USCIS) Office That Granted the Designation

1.d. Civil Surgeon Identification Number (CSID) (if known)

2.a. Has USCIS ever revoked your designation?

☐ Yes ☐ No

If you answered "Yes" to **Item Number 2.a.**, provide the following information.

2.b. Date of Revocation (mm/dd/yyyy)

3.a. Have you ever voluntarily terminated your designation?

☐ Yes ☐ No

If you answered "Yes" to **Item Number 3.a.**, provide the following information.

3.b. Date of Voluntary Termination (mm/dd/yyyy)

NOTE: If you answered "Yes" to **Item Number 2.a.** or **Item Number 3.a.**, above, include a typed or printed explanation of the circumstances surrounding the revocation or voluntary termination in **Part 9. Additional Information**.

Your Full Name

4.a. Family Name (Last Name)

4.b. Given Name (First Name)

4.c. Middle Name

Other Names Used

List all other names you have ever used, including aliases, maiden name, and nicknames. If you need extra space to complete this section, use the space provided in **Part 9. Additional Information**.

5.a. Family Name (Last Name)

5.b. Given Name (First Name)

5.c. Middle Name

Other Information

6. Date of Birth (mm/dd/yyyy)

7. Gender ☐ Male ☐ Female

Part 1. Information About You (The Applicant) (continued)

8. USCIS Online Account Number (if any)

►

9. Alien Registration Number (A-Number, if any)

► **A-**

Part 2. Clinical Office Locations

Provide the following information about the locations where you seek to perform immigration medical examinations. If you seek to perform immigration medical exams in more than one location, provide the details for each additional location in the space provided in **Part 9. Additional Information**.

Name and Physical Address of the Clinic/Practice

You must provide the following information. Failure to provide this information may result in the denial of your application. See the **Additional Office Information** section below for more information about what will be made publicly available.

1. Name of Clinic/Practice

2.a. Street Number and Name

2.b. ☐ Apt. ☐ Ste. ☐ Flr.

2.c. City or Town

2.d. State **2.e.** ZIP Code

(USPS ZIP Code Lookup)

3. Telephone Number

4. Fax Number

5. Email Address (For Use By USCIS)

NOTE: USCIS will use the contact information listed above for all civil surgeon-related communication.

UPDATE USCIS OF ANY CHANGES: Civil surgeons are responsible for notifying USCIS in writing of any updates to the contact information provided in this application **within 15 days of the change.** Visit the USCIS website at **www.uscis.gov/I-910** for information on how to submit a change.

Additional Office Information

Your application will not be affected if you choose not to provide the following information. USCIS displays this information on our website for people who want to find a civil surgeon.

6. ☐ Email Address (For Use By The Public)

7. ☐ Website Address (URL)

8. ☐ Fees for Medical Examination

9. ☐ Acceptable Means of Payment

10. ☐ Accepted Medical Insurance Plans

11. ☐ Languages Spoken

12. ☐ Office Hours

13. ☐ Handicap Accessibility

14. ☐ Other

Part 3. Information About Your Status in the United States

You must be authorized to work in the United States to be eligible for civil surgeon designation. Select the box that accurately states how you are authorized to work in the United States. (Select **only one** box.)

1. ☐ I am a U.S. citizen or national. (Attach proof that you are a U.S. citizen or national, such as a copy of a U.S. passport, birth certificate, or Certificate of Naturalization.)

2. ☐ I am a Lawful Permanent Resident. (Attach a copy of your valid Form I-551, Permanent Resident Card. If you are currently seeking to renew or replace your Form I-551, attach evidence showing that you are doing so.)

Part 3. Information About Your Status in the United States (continued)

3.a. ☐ I am currently present in the United States as a nonimmigrant. (Attach a copy of your Form I-94 Arrival-Departure Record, a copy of your passport or travel document, and any documents related to your nonimmigrant status, such as a copy of the petition, petition approval, and change or extension of status application. Also attach a copy of your valid, unexpired Employment Authorization Document as proof of your authorization to work in the United States, if required.)

3.b. Date of Last Arrival in the U.S. (mm/dd/yyyy)

3.c. Form I-94 Arrival-Departure Record Number (if any)
►

3.d. Passport Number

3.e. Travel Document Number

3.f. Country of Issuance for Passport or Travel Document

3.g. Expiration Date for Passport or Travel Document (mm/dd/yyyy)

3.h. Current Nonimmigrant Status

4. ☐ I have an Employment Authorization Document (EAD) granted by USCIS that authorizes me to work in the United States. (Attach a copy of your valid, unexpired EAD as proof of your authorization to work in the United States.)

Part 4. Medical Licenses

You must be licensed to practice medicine in the state or U.S. territory in which you seek to perform immigration medical examinations to be eligible for civil surgeon designation. **Attach a copy of each medical license listed below.** If you need extra space to complete this section, use the space provided in **Part 9. Additional Information**.

Medical License 1

1.a. State **OR**

U.S. Territory

1.b. Medical License Number

1.c. Date Issued (mm/dd/yyyy)

1.d. Date Expires (mm/dd/yyyy)

Medical License 2

2.a. State **OR**

U.S. Territory

2.b. Medical License Number

2.c. Date Issued (mm/dd/yyyy)

2.d. Date Expires (mm/dd/yyyy)

Part 5. Medical Degrees

You must possess a medical degree as a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) to be eligible for civil surgeon designation. **Attach a copy of each medical degree listed below.** If you need extra space to complete this section, use the space provided in **Part 9. Additional Information**.

School 1

1.a. School Name

1.b. Dates of Attendance (mm/dd/yyyy)
From To

1.c. Degree

School 2

2.a. School Name

2.b. Dates of Attendance (mm/dd/yyyy)
From To

2.c. Degree

Part 6. Professional Experience

You must establish that you have practiced medicine as a physician (M.D. or D.O.) for at least four years to be eligible for designation.

NOTE: In calculating whether you meet the requirement of four years of practice as a physician, DO NOT count your post graduate medical training in an internship or residency program. You can, however, count the time you practiced medicine on the basis of a post-residency fellowship.

Submit evidence to establish your professional experience, such as evaluations, certificates of completion, business tax returns and business license (for self-employed physicians), or letters of employment verification. If you need extra space to complete this section, use the space provided in **Part 9. Additional Information**.

Employer 1

1.a. Employer's Name

1.b. Dates of Employment (mm/dd/yyyy)
From To

1.c. Street Number and Name

1.d. ☐ Apt. ☐ Ste. ☐ Flr.

1.e. City or Town

1.f. State **1.g.** ZIP Code

1.h. Employer's Daytime Telephone Number

Employer 2

2.a. Employer's Name

2.b. Dates of Employment (mm/dd/yyyy)
From To

2.c. Street Number and Name

2.d. ☐ Apt. ☐ Ste. ☐ Flr.

2.e. City or Town

2.f. State **2.g.** ZIP Code

2.h. Employer's Daytime Telephone Number

Part 7. Applicant's Statement, Contact Information, Declaration, Certification, and Signature

NOTE: Read the **Penalties** section of the Form I-910 Instructions before completing this section. You must file Form I-910 while in the United States.

Applicant's Statement

NOTE: If applicable, select the box for **Item Number 1.**

1. ☐ At my request, the preparer named in **Part 8.**, _____, prepared this application for me based only upon information I provided or authorized.

Applicant's Contact Information

2. Applicant's Daytime Telephone Number

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

4. Applicant's Email Address (if any)

Applicant's Declaration and Certification

By signing this application, I accept civil surgeon designation if my request for designation is granted. Once designated as a civil surgeon, I agree that I will perform the medical examinations according to the regulations published by Health and Human Services (HHS) at 42 CFR Part 34 and the *Technical Instructions for Civil Surgeons* by the Centers for Disease Control and Prevention (CDC).

By signing this application, I further agree to comply fully with the regulations at 8 CFR Part 232. I understand that USCIS reserves the right to revoke civil surgeon designation in certain circumstances.

Copies of any documents I have submitted are exact photocopies of unaltered, original documents, and I understand that USCIS may require that I submit original documents to USCIS at a later date. Furthermore, I authorize the release of any information from any and all of my records that USCIS may need to determine my eligibility for designation as a civil surgeon.

I furthermore authorize release of information contained in this application, 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.

Part 7. Applicant's Statement, Contact Information, Declaration, Certification, and Signature (continued)

I certify, under penalty of perjury, that all of the information in my application and any document submitted with it were provided or authorized by me, that I reviewed and understand all of the information contained in, and submitted with, my application and that all of this information is complete, true, and correct.

Applicant's Signature

5.a. Applicant's Signature

5.b. Date of Signature (mm/dd/yyyy)

NOTE TO ALL APPLICANTS: If you do not completely fill out this application or fail to submit required documents listed in the Instructions, USCIS may deny your application.

Part 8. 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.a. Preparer's Family Name (Last Name)

1.b. Preparer's Given Name (First Name)

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

Preparer's Mailing Address

3.a. Street Number and Name

3.b. ☐ Apt. ☐ Ste. ☐ Flr.

3.c. City or Town

3.d. State **3.e.** ZIP Code

3.f. Province

3.g. Postal Code

3.h. 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)

7. ☐ Select this box if the preparer may act as a secondary point of contact for you. USCIS will contact this preparer if you cannot be reached using the information in **Part 2.**

Preparer's Statement

8.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.

8.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 Declaration and 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

9.a. Preparer's Signature

9.b. Date of Signature (mm/dd/yyyy)

Part 9. Additional Information

If you need extra space to provide any additional information within this application, use the space below. If you need more space than what is provided, you may make copies of this page to complete and file with this application or attach a separate sheet of paper. Type or print your name and CSID 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.a. Family Name (Last Name)

1.b. Given Name (First Name)

1.c. Middle Name

2. CSID Number (if any)

3.a. Page Number **3.b.** Part Number **3.c.** Item Number

3.d.

4.a. Page Number **4.b.** Part Number **4.c.** Item Number

4.d.

5.a. Page Number **5.b.** Part Number **5.c.** Item Number

5.d.

6.a. Page Number **6.b.** Part Number **6.c.** Item Number

6.d.

7.a. Page Number **7.b.** Part Number **7.c.** Item Number

7.d.