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 03/31/2017

► **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. Name

Family Name (Last Name)	Given Name (First Name)	Middle Name
Yuque Delachaux	Mario	

2. Home Address

Street Number and Name	Apt. Ste. Flr.	Number
1827 N California Ave	☒ Apt ☐ Ste ☐ Flr	1

City or Town	State	ZIP Code
Chicago	IL	60647

3. Gender ☒ Male ☐ Female

4. Daytime Telephone Number: 4079531972

5. Mobile Telephone Number (if any): 4079531972

6. Email Address (if any): marioyuque@gmail.com

7. Date of Birth (mm/dd/yyyy): 06/02/1982

8. City/Town/Village of Birth: Havana

9. Country of Birth: Cuba

10. Alien Registration Number (A-Number) (if any)
► **A-** 202188702

Applicant's Certification

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 benefit request 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.

NOTE: Select the box for either **Item Number 11. or 12.**

11. ☒ I can read and understand English, and have read and understand every question and instruction in **Part 1.** of this Form I-693, as well as my answer to every question in **Part 1.** I have read and understand the above **Applicant's Certification**.

12. ☐ The interpreter named in **Part 2.** has read to me every question and instruction in **Part 1.** of this Form I-693, as well as my answer to every question in **Part 1.**, in _____, a language in which I am fluent. I understand every question and instruction in **Part 1.** of this Form I-693 as translated to me by my interpreter, and have provided complete, true, and correct responses in the language indicated above. The interpreter named in **Part 2.** also has read the above **Applicant's Certification** to me, in a language in which I am fluent, and I understand the **Applicant's Certification** as read to me by my interpreter.

Applicant's Signature

13. Signature - Do not sign or date Form I-693 until instructed to do so by the civil surgeon **Date of Signature** (mm/dd/yyyy): 11/02/2015

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

Part 1. Information About You (To be completed by the person requesting a medical examination, **NOT** the civil surgeon) (continued)

14. To be completed by the civil surgeon:

A. Form of applicant identification presented (for example, passport or driver's license)

B. Identification Number

Part 2. Interpreter's Contact Information, Certification and Signature

Provide the following information concerning the interpreter.

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)

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 Email Address (if any)

Interpreter's Certification

I certify that:

I am fluent in English and **,** which is the same language provided in **Part 1.**, **Item Number 12.**;

I have read to this applicant every question and instruction in **Part 1.** of this Form I-693, as well as the answer to every question in **Part 1.**, in the language provided in **Part 1.**, **Item Number 12.**; and

I have read the **Applicant's Certification** to the applicant in the same language provided in **Part 1.**, **Item Number 12.**

The applicant has informed me that he or she understands every instruction and question in **Part 1.** of this Form I-693, as well as the answer to every question in **Part 1.**, and the applicant verified the accuracy of every answer; and

The applicant also has informed me that he or she understands the **Applicant's Certification**.

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

Part 2. Interpreter's Contact Information, Certification and Signature (continued)

Interpreter's Signature

6. Interpreter's Signature

Date of Signature (mm/dd/yyyy)

Part 3. 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 5. Civil Surgeon Worksheet** of this benefit request.)

C. ☐ Class A Conditions (See **Item Numbers 1. - 3.** in **Part 5. Civil Surgeon Worksheet** of this benefit request.)

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 4. Civil Surgeon's Contact Information, Certification, and Signature (Do not sign Form I-693 and do not have the applicant sign in **Part 1.** until all health-related follow-up requirements are met.)

Civil Surgeon's Information

1. Family Name (Last Name) | Given Name (First Name) | Middle Name (if applicable)

2. Name of Medical Practice, Facility, or Health Department

Physical Address

3. Street Number and Name | Apt. ☐ Ste. ☐ Flr. ☐ | Number

City or Town | State | ZIP Code

Contact Information

4. Daytime Telephone Number

5. Email Address (if any)

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

Part 4. Civil Surgeon's Contact Information, Certification, and Signature (Do not sign Form I-693 and do not have the applicant sign in **Part 1.** until all health-related follow-up requirements are met.) (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 medical examinations, unless otherwise exempted;

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

6. 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 5. Civil Surgeon Worksheet (To be completed by the civil surgeon, according to the *Technical Instructions* at www.cdc.gov/immigrantrefugeehealth/exams/ti/civil/technical-instructions-civil-surgeons.html)

1. Communicable Disease of Public Health Significance

A. Tuberculosis (TB): An initial screening test, either a tuberculin skin test (TST) or an interferon gamma release assay (IGRA), is required for all applicants 2 years of age and older; for children under 2 years of age, see the *Technical Instructions*. The civil surgeon should perform only **one type of initial screening test**, followed by further evaluation if needed (chest X-ray).

(1) Tuberculin Skin Test:

☐ Not administered (TST exception; please explain in Remarks section below)

Date TST Applied (mm/dd/yyyy) | Date TST Read (mm/dd/yyyy) | Size of Reaction (mm)

Result: ☐ Negative (4mm or less of induration) ☐ Positive (≥ 5mm; chest X-ray required)

(2) Interferon Gama Release Assay (for acceptable IGRA's, consult the *Technical Instructions* and any updates posted on the CDC's Web site):

☐ Not administered (IGRA exception; please explain in Remarks section below)

Select **only one** box.

☐ QuantiFERON — Date Blood Sample Drawn (mm/dd/yyyy)

☐ T-Spot — Date Blood Sample Drawn (mm/dd/yyyy)

Result: ☐ Negative (including indeterminate, or borderline/equivocal) (no chest X-ray required)

☐ Positive (chest X-ray required)

(3) Initial Screening Test Result and Chest X-Ray Determinations:

☐ Chest X-ray not required (medically cleared for TB for USCIS)

☐ Chest X-ray required due to initial screening test results

☐ Chest X-ray required due to TB signs or symptoms, or due to immunosuppression (such as HIV)

☐ Chest X-ray required due to TST or IGRA exception (Clearly specify the TST or IGRA exception in the Remarks section below.)

(4) Chest X-Ray: Required based on TST or IGRA result, or if specific TST or IGRA exceptions apply, or for an applicant with TB signs or symptoms or immunosuppression (such as HIV).

Date Chest X-Ray Taken (mm/dd/yyyy) (mm/dd/yyyy) | Date Chest X-Ray Read (mm/dd/yyyy)

Result: ☐ Normal ☐ Abnormal (describe results in Remarks section below.)

TB Classification/Findings (Select only if chest X-ray was performed):

☐ No Class A or Class B TB

☐ Class A Pulmonary TB Disease

☐ Class B1 Pulmonary TB

☐ Class B1 Extra Pulmonary TB

☐ Class B2 Pulmonary TB

☐ Class B, Other Chest Condition (non-TB)

☐ Class B, Latent TB Infection (Answer the following question.)

Was applicant referred for treatment (not required to complete Form I-693)? ☐ Yes ☐ No

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

Part 5. Civil Surgeon Worksheet (To be completed by the civil surgeon, according to the *Technical Instructions* at www.cdc.gov/immigrantrefugeehealth/exams/ti/civil/technical-instructions-civil-surgeons.html)

(5) Remarks: (Include any signs or symptoms of TB, additional tests and therapy given, with start and stop dates and any changes. If you did not perform TST or IGRA, give the reason why an exception applies.)

B. Syphilis

(1) Serologic Test for Syphilis (Required for applicants 15 years of age and older)

(a) Date Screening Run (mm/dd/yyyy)

(b) ☐ Screening Nonreactive ☐ Screening Reactive, Titer 1:

(c) If Reactive, Date Confirmation Run (mm/dd/yyyy)

(d) ☐ Confirmation Nonreactive ☐ Confirmation Reactive, Titer 1:

(2) Findings:

☐ No Class A or Class B Syphilis ☐ Syphilis, Class A (untreated) ☐ Syphilis, Class B (treated in the last year)

(3) Remarks: (Include any therapy given with doses and dates)

C. Other Class A/Class B Conditions for Communicable Diseases of Public Health Significance

(1) Findings:

(a) ☐ No Class A/B Condition

(b) ☐ Chancroid, Class A

(c) ☐ Granuloma Inguinale, Class A

(d) ☐ Gonorrhea, Class A

(e) ☐ Lymphogranuloma Venereum, Class A

(f) ☐ Hansen's Disease (leprosy, any classification) untreated, Class A

☐ Indeterminate, tuberculoid, borderline tuberculoid (paucibacillary)

☐ Mid-borderline, borderline lepromatous, lepromatous (multibacillary)

(g) ☐ Hansen's Disease (leprosy, any classification) treated or partially treated, Class B

☐ Indeterminate, tuberculoid, borderline tuberculoid (paucibacillary)

☐ Mid-borderline, borderline lepromatous, lepromatous (multibacillary)

(2) Remarks: (Include any therapy given and any counseling or referrals)

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

Part 5. Civil Surgeon Worksheet (To be completed by the civil surgeon, according to the *Technical Instructions* at www.cdc.gov/immigrantrefugeehealth/exams/ti/civil/technical-instructions-civil-surgeons.html)

2. Physical or Mental Disorders With Associated Harmful Behavior

Include here any physical or mental disorders with current associated harmful behavior or history of associated harmful behavior judged likely to recur. This category of physical or mental disorders includes any diagnosis of substance-related disorders based on Diagnostic and Statistical Manual (DSM) criteria for a substance that is not listed in Schedule I, II, III, IV, or V of section 202 of the Controlled Substances Act (for example, diagnosis of an alcohol-related disorder).

A. Findings:

- **(1)** ☐ No Class A or B Physical or Mental Disorder
- **(2)** ☐ Current Physical/Mental Disorder with Associated Harmful Behavior, Class A
- **(3)** ☐ History of Physical/Mental Disorder with Associated Harmful Behavior Likely to Recur, Class A
- **(4)** ☐ Current Physical/Mental Disorder without Associated Harmful Behavior, Class B
- **(5)** ☐ History of Physical/Mental Disorder with Associated Harmful Behavior Unlikely to Recur, Class B

B. Remarks: (Include diagnosis, likelihood of recurrence of the harmful behavior, therapy given, and any counseling or referrals. If you need more space, attach a separate sheet of paper; type or print the applicant's name and A-Number (if any), at the top of each sheet; and indicate the **Page Number**, **Part Number**, and **Item Number** to which your answer refers.)

3. Drug Abuse/ Drug Addiction

"Drug Abuse/Drug Addiction" addresses non-medical use **only** with respect to substances listed in Schedule I, II, III, IV, or V of section 202 of the Controlled Substances Act. Include here any diagnosis of substance-related disorders based on DSM criteria for a substance listed in Schedule I, II, III, IV, or V of section 202 of the Controlled Substances Act. See CDC's *Technical Instructions* for more information.

A. Findings:

- **(1)** ☐ No Class A or B Substance (Drug) Abuse/Addiction
- **(2)** ☐ Substance (Drug) Abuse/Addiction, Listed in section 202 of the Controlled Substances Act, Class A
- **(3)** ☐ Substance (Drug) Abuse/Addiction in Full Remission, Listed in section 202 of the Controlled Substances Act, Class B

B. Remarks: (Include any therapy given, rehabilitation, counseling or referrals. If you need more space, attach a separate sheet of paper; type or print the applicant's name and A-Number (if any), at the top of each sheet; and indicate the **Page Number**, **Part Number**, and **Item Number** to which your answer refers.)

4. Other Medical Conditions (List any other Class B conditions, such as hypertension or diabetes.)

5. Required Referral to Health Department or Other Doctor (To be completed by civil surgeon, if referral is medically required. Do not complete if referral is not required, such as recommended referral for LTBI treatment.)

A. Type or Print Name of Doctor or Health Department Receiving Required Referral

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

Part 5. Civil Surgeon Worksheet (To be completed by the civil surgeon, according to the *Technical Instructions* at **www.cdc.gov/immigrantrefugeehealth/exams/ti/civil/technical-instructions-civil-surgeons.html**) (continued)

B. Address

Street Number and Name | Apt. Ste. Flr. | Number

City or Town | State | ZIP Code

C. Date of Referral (mm/dd/yyyy)

D. Remarks: (Include name of medical condition and reasons for referral. If you need more space, attach a separate sheet of paper; type or print the applicant's name and A-Number (if any), at the top of each sheet; and indicate the **Page Number**, **Part Number**, and **Item Number** to which your answer refers.)

Part 6. Referral Evaluation (To be completed by the health department or other doctor performing the referral evaluation)

The applicant identified on this Form I-693 was referred to me by the civil surgeon named in **Part 4.** of this Form I-693. I have provided appropriate evaluation/treatment, having made every reasonable effort to verify that the person whom I have evaluated/ treated is the person identified in **Part 1**.

1. Type or print full name of evaluating physician or health department

Family Name (Last Name) | Given Name (First Name) | Middle Name

2. Address

Street Number and Name | Apt. Ste. Flr. | Number

City or Town | State | ZIP Code

3. Signature | **Date Signed** (mm/dd/yyyy)

4. Name of Medical Practice or Health Department | **5. Daytime Telephone Number**

6. Remarks: If you need more space, attach a separate sheet of paper; type or print the applicant's name and Alien Registration Number (A-Number) (if any), at the top of each sheet; and indicate the **Page Number**, **Part Number**, and **Item Number** to which your answer refers.

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

Part 7. Vaccination Record (See *Technical Instructions* at www.cdc.gov/immigrantrefugeehealth/exams/ti/civil/vaccination-civil-technical-instructions.html for list of required vaccines)

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 page with **Part 1.**, **Part 2.**, and **Part 4.** of Form I-693 (the applicant, regardless of what is required, may still need an interpreter). For more information, see Form I-693 Instructions, **Part 3. Frequently Asked Questions.**

Vaccine History Transferred From A Written Record					**Vaccine Given**	**Complete Series**	**Blanket Waivers 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	Not Flu Season
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							☐	☐	☐	

NOTE: Give a copy to the applicant.

Results:

☐ Applicant may be eligible for blanket waivers 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

Remarks: (If needed, provide any comments, such as the reason for contraindication.)

FOR USCIS USE ONLY
Remarks (if any)**:**