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 02/28/2019

▶ **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 Name**

Family Name (Last Name)	Given Name (First Name)	Middle Name
AGRAWAL	SHIKHA	

2. **Physical Address**

Street Number and Name	Apt. Ste. Flr.	Number
35 RIVER DR S	☒ Apt ☐ Ste ☐ Flr	311

City or Town	State	ZIP Code
JERSEY CITY	NJ	07310

3. **Other Information**

A. Sex
☐ Male ☒ Female

B. Date of Birth (mm/dd/yyyy)
10/23/1987

C. City/Town/Village of Birth
BARA DISTRICT KALAIYA

D. Country of Birth
NEPAL

E. Alien Registration Number (A-Number) (if any)
▶ A-

F. USCIS Online Account Number (if any)
▶

Part 2. Applicant's Statement, Contact Information, Certification, and Signature

NOTE: Read the **Penalties** section of the Form I-693 Instructions before completing this Part. You must submit Form I-693 in a sealed envelope to USCIS as directed in the Form I-693 Instructions.

Applicant's Statement

NOTE: Select the box for either **Item A.** or **B.** in **Item Number 1.**

1. Applicant's Statement Regarding the Interpreter

A. ☒ I can read and understand English, and I have read and understand every question and instruction on this form and my answer to every question.

B. ☐ The interpreter named in **Part 3.** read to me every question and instruction on this form and my answer to every question in _____, a language in which I am fluent, and I understood everything.

Applicant's Contact Information

2. Applicant's Daytime Telephone Number
2563356192

3. Applicant's Mobile Telephone Number (if any)
2563356192

4. Applicant's Email Address (if any)
SHIKHA120@GMAIL.COM

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

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

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 Mobile Telephone Number (if any)

6. Interpreter's Email Address (if any)

Interpreter's Certification

I certify, under penalty of perjury, that:

I am fluent in English and _____, which is the same language specified in **Part 2., Item B.** in **Item Number 1.**, and I have read to this applicant in the identified language every question and instruction on this form and his or her answer to every question. The applicant informed me that he or she understands every instruction, question, and answer on the form, including the **Applicant's Certification**, and has verified the accuracy of every answer.

Interpreter's Signature

7. Interpreter's Signature

Date of Signature (mm/dd/yyyy)

Parts 4. - 9. of this form must be completed by the civil surgeon.

Part 4. 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)

NEW JERSEY DRIVER LICENSE

2. Document Identification Number

A31097080060872

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

Part 6. 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-related 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-related 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*, 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 J Patel

Date of Signature (mm/dd/yyyy) 05/12/2017

(Health departments and military treatment facilities MUST place their official stamp or seal here)

DR JAYESH PATEL, M.D.
550 SUMMIT AVE. BASEMENT
JERSEY CITY NJ 07306
201-209-1802

(official stamp or seal here)

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

Part 7. Civil Surgeon Worksheet (continued)

(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) Name of Screening Test: RPR

(b) Date Screening Run (mm/dd/yyyy): 05/08/2017

(c) ☒ Screening Nonreactive (mm/dd/yyyy): 05/09/2017

☐ Screening Reactive, Titer 1:

(d) If Reactive, Name of Confirmatory Test:

(e) Date Confirmation Run (mm/dd/yyyy):

(f) ☐ Confirmation Nonreactive ☐ Confirmation Reactive

(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)

Drug: Dosage:

Start Date (mm/dd/yyyy): End Date (mm/dd/yyyy):

C. Gonorrhea

(1) Laboratory Test for Gonorrhea (Required for applicants 15 years of age and older)

(a) Screening Test Name: NEISSERIA GONORRHOEAE

(b) Date Specimen Reported (mm/dd/yyyy): 08/09/2016

(c) ☐ Positive ☒ Negative

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

Part 7. Civil Surgeon Worksheet (continued)

B. Remarks: (Include diagnosis, likelihood of recurrence of the harmful behavior, therapy given, and any counseling or referrals. If you need extra space to complete this section, use the space provided in **Part 10. Additional Information**.

3. **Drug Abuse/ Drug Addiction**

The U.S. Department of Health and Human Services (DHHS) sets the medical guidelines for determining drug abuse and drug addiction. The terms are defined at 42 CFR 34.2(h) and (i).

Include here any diagnosis of drug abuse or drug addiction.

"Drug abuse" is "current substance use disorder or substance-induced disorder, mild," **but only** with respect to substances listed in Schedule I, II, III, IV, or V of section 202 of the Controlled Substances Act. Make the diagnosis according to the diagnostic criteria in the most current edition of the DSM, or by another authoritative source as determined by the director of the CDC.

"Drug addiction" is "current substance use disorder or substance-induced disorder, moderate or severe," **but only** with respect to substances listed in Schedule I, II, III, IV, or V of section 202 of the Controlled Substances Act. Make the diagnosis according to the diagnostic criteria in the most current edition of the DSM.

You may also make a diagnosis of full remission, according to the diagnostic criteria in the most current edition of the DSM or another authoritative source as determined by the director of the CDC. See the CDC's Technical Instructions for more information.

A. Findings:

(1) ☒ No Class A or B Substance (Drug) Abuse/Addiction

(2) ☐ Substance (Drug) **Abuse**, Listed in section 202 of the Controlled Substances Act, Class A

(3) ☐ Substance (Drug) **Addiction**, Listed in section 202 of the Controlled Substances Act, Class A

(4) ☐ Substance (Drug) **Abuse** in Full Remission, Listed in section 202 of the Controlled Substances Act, Class B

(5) ☐ Substance (Drug) **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 extra space to complete this section, use the space provided in **Part 10. Additional Information**.

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

NONE

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

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

NOT APPLICABLE

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

Part 9. Vaccination Record

NOTE: 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., Part 3., Part 4.,** and **Part 6.** 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 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 ☐	08/26/2013						☐	☐	☐	
Specify Vaccine: OPV ☐ IPV ☐							☒	☐	☐	
MMR (measles, mumps-rubella) or if monovalent or other combination of the vaccines are given, specify vaccines	11/13/2012	10/02/2012					☐	☐	☐	
Hib							☒	☐	☐	
Hepatitis B							☒	☐	☐	
Varicella						05/08/2017	☐	☐	☐	
Pneumococcal							☒	☐	☐	
Influenza							☐	☐	☐	☒
Rotavirus							☒	☐	☐	
Hepatitis A							☒	☐	☐	
Meningococcal							☒	☐	☐	

NOTE: Give a copy to the applicant.

Part 10. Additional Information

If you (the applicant or the civil surgeon) need extra space to provide any additional information within this form use the space below. If you (the applicant or civil surgeon) need more space than what is provided, you may make copies of this page to complete and file with this form or attach a separate sheet of paper. Type or print the applicant's name and A-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. Family Name (Last Name): AGRAWAL | Given Name (First Name): SHIKHA | Middle Name:

2. A-Number (if any) ▶ A-

3. **A.** Page Number **B.** Part Number **C.** Item Number

   D.

4. **A.** Page Number **B.** Part Number **C.** Item Number

   D.

5. **A.** Page Number **B.** Part Number **C.** Item Number

   D.

6. **A.** Page Number **B.** Part Number **C.** Item Number

   D.

BCL
BEST CARE LABORATORY

14 APPLEGATE DR, S# B
ROBBINSVILLE, NJ 08691-2342
(609)838-9890

Farhad Setoodeh M.D.
Laboratory Directory
CLIA ID# 31D2039164

Client: **PATEL, JAYESHKUMAR** 3168 550 SUMMIT AVE BSMT JERSEY CITY, NJ 07306 (201) 209-1802 Phys:	Patient: **AGRAWAL, SHIKHA** Room# DOB. 10/23/1987 Age:29 Sex:F Phone: (256) 335-6192 ID#: A1705080116 Route#: 0 Page:1

Acc# **1705080116**	Coll. Date: 05/08/17	Recv. Date: 05/08/17	Print Date: 05/12/17
Chart#	Coll. Time:	Recv. Time:11:47 PM	Print Time: 14:18
First reported on:	05/09/17	Final report date:	05/09/17

Test Name	Results	Normal Range	Units
Report Status: FINAL		**NONFASTING**	
***********OUT OF RANGE SUMMARY***********			
VARICELLA IGG	223 Positive	<135 Negative	INDEX
SPECIAL CHEMISTRY			
VARICELLA IGG	223 Positive	<135 Negative	INDEX
SEROLOGY			
RPR	NONREACT	NONREACT	

-------------------------------- END OF REPORT --------------------------------

Shiel

Patient Name: Agrawal, Shikha
DOB: October 23, 1987

Requisition	Patient	Physician
Accession #: 23794564	Agrawal, Shikha	Solano Padilla, Rocio
Ordered on:	35 River Drive	**NPI:** 1003155235
Last update: August 14, 2016, 15:51:00	Apt. 311	**Account #:** 44013
Lab reference id: Shiel-683171	Jersey City, New Jersey 07310	
	256-335-6192	
	ID: 1934824	
	DOB: October 23, 1987	
	Gender: Female	

Urine Culture — August 09, 2016 — F

Analyte	Value	Range	Site	
< 10,000	< 10,000			
Source	Regular Urine			

Test Performed at:
Shiel Medical Laboratory(Shiel Medical Laboratory), 63 Flushing Ave, Brooklyn, NY 11205; Phone#: 718-552-1000
Laboratory Director: Patricia Romano, MD

Bacterial Vaginosis/vaginitis Panel — August 09, 2016 — F

Analyte	Value	Range	Site	
Candida species	Not Detected	Not Detected		
Trichomonas vaginalis	Not Detected	Not Detected		
Gardnerella vaginalis	**Detected**	**Not Detected**		**H**

Methodology: Nucleic Acid Hybridization.

TP DX Ref HPV Ref HPV 16/18 — August 09, 2016 — F

Analyte	Value	Range	Site
Result Code	Negative		
Cytological Diagnosis	Within normal limits		
Specimen Adequacy			
Satisfactory for evaluation. Endocervical/transformation zone present.			
General Categorization	Negative for Intraepithelial Lesion or Malignancy.		
Descriptive Comments			
This case has been screened with location guidance from the Hologic ThinPrep Imaging System.			
CT SCREENED BY	Dawit Arega, CT (ASCP)		
Source	Cervical		
Date of LMP	20160715		

CT/GC Amplified Aptima — August 09, 2016 — F

Analyte	Value	Range	Site
C. trachomatis, RNA, TMA	Negative	Negative	
N. gonorrhea, RNA, TMA	Negative	Negative	

HIV 1/2 Ag/Ab 4th generation — August 09, 2016 — F

Analyte	Value	Range	Site
HIV 1/2 Ag/Ab 4th generation	Non-reactive	Non-reactive	

Please note: The performance of this assay has not been established with cord blood, neonatal (infant) specimens, heat-inactivated specimen, or body fluids other than serum or plasma. It has not been FDA cleared or approved for use in screening blood or plasma donors. The results of this assay are protected by various State laws, which are specific to individual State Department of Health and

Immunization | Health Test

Shikha Agrawal 00001346803

Immunizations Find | View 1 First 1-3 of 3 Last

*Immunization: MEAS Measles *Immunization Number: 2
Date Taken: Expiration Date:
Date Received: *Immunization Status: Complete
Comment:

Immunization Criteria Find | View All First 1 of 4 Last

*Criteria Number: 1 Does Not Apply Test Taken Test Not Taken
Description: Measles Vaccine 1
Date Taken: Expiration Date:
Date Received: Immunization Status:

*Immunization: MMR Measles, Mumps, Rubella 1
Date Taken: Expiration Date:
Date Received: *Immunization Status: Unknown
Comment:

Immunization Criteria Find | View 1 First 1-2 of 2 Last

*Criteria Number: 1 Does Not Apply Test Taken Test Not Taken
Description: MMR Vaccine 1
Date Taken: 10/02/2012 Expiration Date:
Date Received: Immunization Status:

*Criteria Number: 2 Does Not Apply Test Taken Test Not Taken
Description: MMR Vaccine 2
Date Taken: 11/13/2012 Expiration Date:
Date Received: Immunization Status:

*Immunization: T/D Tetanus/Diphtheria 3
Date Taken: Expiration Date: 10/02/2013
Date Received: *Immunization Status: Unknown
Comment:

Immunization Criteria Find | View 1 First 1-5 of 5 Last

*Criteria Number: 1 Does Not Apply Test Taken Test Not Taken
Description: T/D Booster
Date Taken: 08/26/2013 Expiration Date:
Date Received: Immunization Status:

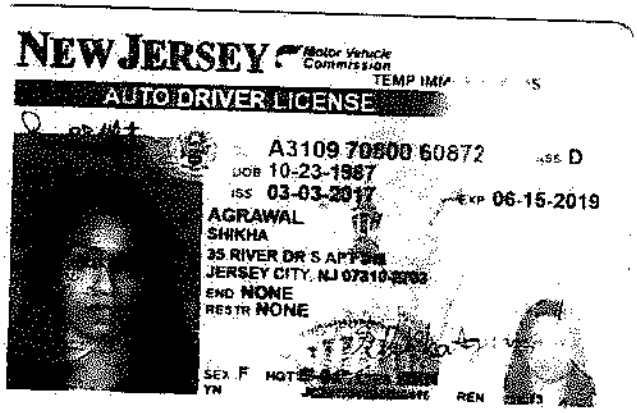
*Criteria Number: 2 Does Not Apply Test Taken Test Not Taken
Description: T/D Vaccine 1
Date Taken: 10/02/2012 Expiration Date:
Date Received: Immunization Status:

*Criteria Number: 3 Does Not Apply Test Taken Test Not Taken
Description: T/D Vaccine 2
Date Taken: 11/13/2012 Expiration Date:
Date Received: Immunization Status:

*Criteria Number: 4 Does Not Apply Test Taken Test Not Taken
Description: T/D Vaccine 3
Date Taken: Expiration Date:
Date Received: Immunization Status:

*Criteria Number: 5 Does Not Apply Test Taken Test Not Taken
Description: T/D Temp Exempt

Wellness Center
Loyola University Chicago
1052 Loyola Avenue
Chicago, IL 60626



NEW JERSEY Motor Vehicle Commission

TEMP IMP

AUTO DRIVER LICENSE

A3109 70600 60872 CLASS D

DOB 10-23-1987

ISS 03-03-2017 EXP 06-15-2019

AGRAWAL

SHIKHA

35 RIVER DR S APT [redacted]

JERSEY CITY, NJ 07310-[redacted]

END NONE

RESTR NONE

SEX F HGT [redacted]

YN

REN

MVC

Rev 07-23-2010

SA10-23-1987

ENDORSEMENTS:
None

RESTRICTIONS:
None

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