Immigration Visit Price List & Instructions

Immigration Physical	$200.00*
Required Vaccinations	
Current year Influenza Vaccination	$30.00 -$55.00*
Chicken Pox (Varicella)	$155.00*
Measles, Mumps & Rubella (MMR)	$90.00*
Tetanus- Diphtheria-Pertussis	$55.00*
Bloodwork (RPR, TB & Gonorrhea)	$135.00* Draw Fee $15.00*

***price subject to change**

**** Patients over the **age of 65 are not required** to have the Measles, Mumps & Rubella vaccination but are required to have the pneumococcal vaccination which has a cost of $200.00.

You must bring a government issued form of identification as well as records of any vaccinations that you have received.

If the results of your Lab test are abnormal, additional testing and or treatment will be necessary at your expense.

We only accept insurance for the Bloodwork portion of the .

Cash or Credit is required for all other services at the time of visit.

Immigration Paperwork Instructions

1. Use Black Ink only
2. Do Not Date any of the pages
3. Complete pages 1 and 2 and print your name at the top of pages 2-14.
4. If you have an Interpreter they must complete pages 3 and 4 and they also must be present and have a valid Government issued Identification (Passport, Driver's License , State ID card).
5. If someone other than yourself is completing your form then they must complete pages 1 through 4 and be present with a current form of identification. They must also print your name at the top of pages 2-14.
6. There can be no mistakes of any kind on this paperwork. If you have to correct anything that you have written you must print another page to replace the page that has the mistake.

Washington Travel Immunizations

650 Pennsylvania Avenue S.E. Suite 480, Washington, DC 20003 Ph. (202)546-0062
1400 Mercantile Lane Suite 200, Largo, MD 20774 Ph. (301)773-4100

PATIENT INFORMATION

Date_____ Home Phone (___)_____ Cell Phone(___)_____
Name_____ _____ _____
Last First MI

Social Security/HIC/Patient ID#_____

Address_____
City_____ State_____ Zip code_____

Email Address_____

Sex M F (please circle)
Birthdate_____

Married Separated Divorced Partnered for__years Single Widowed Minor (please circle)

Ethnicity_____
Preferred Language_____

Washington Travel Immunization Center

650 Pennsylvania Avenue S.E. Suite 480 Washington, Dc 20003 Ph. 202 546-0062
1400 Mercantile Lane Suite 200 Largo MD, 20774 Ph. 301 773-4100

Financial Agreement

I, _____ understand that the above named business
(please print name)
(WTIC) does not accept insurance assignment for services provided. Payment in full is accepted at the time of service only, In the form of cash or credit card.

I may have insurance coverage for these services. A receipt will be provided to me at my request to send to my insurance company. Occasionally the insurance company will send the check to WTIC. WTIC will issue a check to me within 30 days of the receipt of such payment. Under no circumstances will WTIC adjust its fees based on the insurance allowance.

I agree to these terms.

_____ _____
(signature) **(name of patient other than self)**

_____ _____
(witness) **(date)**

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Policies and I have been provided an opportunity to review it.

Name: _____ Birth date: _____

Signature: _____ Date: _____

This practice employs Physician Assistants. Physician Assistants are qualified, certified and licensed medical practitioners that function in the same capacity as a Physician under the supervision of a licensed Physician. You may be seen by the Physician Assistant for routine and emergency office visits.

Signature_____

Review of Systems

Please circle the positive responses.

General- fever, night sweats, weight loss, tired, weakness
Head - headaches, head injury, dizziness
Eyes- vision problems, eye pain, eye discharge
Ears – ear ache, ear discharge, hearing problem
Nose- nasal congestion, mucus, discharge, pain, sinus pain
Throat - sore throat, drainage in throat, swelling in neck
Lungs - cough, phlegm, blood in mucus, hard to breathe
Heart - chest pain or tightness, heart problems, high blood pressure, heart attack, high cholesterol
Abdomen – diarrhea, stomach pain, blood in stool, parasites
Skin - rash, sores, bruises, lesions
Psychiatric - moody, depressed, suicidal thoughts, violent behavior, self injury, drug use, alcohol use

Tuberculosis – Have you ever had: a positive skin test? Treatment for TB? BCG vaccine? Chest xray? Contact with someone who has TB?

Vaccinations- **You must bring any vaccine records from your doctor with you at time of the visit.** Have you ever had chicken pox? Measles? Mumps? Hepatitis? Pneumonia? Any other communicable illnesses? STDs?

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 07/31/2022

► **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

2. Physical Address

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

City or Town | State | ZIP Code

(USPS ZIP Code Lookup)

3. Other Information

A. Gender ☐ Male ☐ Female

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

C. City/Town/Village of Birth

D. Country of Birth

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 section. 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.** If applicable, select the box for **Item Number 2.**

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.

2. Applicant's Statement Regarding the Preparer

   ☐ At my request, the preparer named in **Part 4.**, _____, prepared this application for me based only upon information I provided or authorized.

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

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

Applicant's Contact Information

3. Applicant's Daytime Telephone Number

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

5. Applicant's Email Address (if any)

Applicant's Certification

I authorize the release of any information from any and all of my records that USCIS may need to determine my eligibility for the immigration benefit I seek.

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

I understand that USCIS may require me to appear for an appointment to take my biometrics (fingerprints, photograph, and/or signature) and, at that time, if I am required to provide biometrics, I will be required to sign an oath reaffirming that:

1) I reviewed and provided or authorized all of the information in my form;

2) I understood all of the information contained in, and submitted with, my form; and

3) All of this information was complete, true, and correct at the time of filing.

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 form 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.

Applicant's Signature

NOTE: Do not sign or date Form I-693 until instructed to do so by the civil surgeon.

6. Applicant's Signature

Date of Signature (mm/dd/yyyy)

NOTE TO ALL APPLICANTS AND CIVIL SURGEONS: If you or the civil surgeon do not completely fill out this form according to the instructions USCIS may deny your immigration benefit.

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

Provide the following information about the interpreter, if you used one.

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)

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

Part 4. 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. Preparer's Family Name (Last Name)

Preparer's Given Name (First Name)

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

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

Part 4. Contact Information, Declaration, and Signature of the Person Preparing this Application, if Other Than the Applicant (continued)

Preparer's Mailing Address

3. Street Number and Name

Apt. Ste. Flr. ☐ ☐ ☐ Number

City or Town

State

ZIP Code

Province

Postal Code

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)

Preparer's Statement

7. **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.

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 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

8. Preparer's Signature

Date of Signature (mm/dd/yyyy)

Parts 5. - 10. of this form must be completed by the civil surgeon.

Part 5. Applicant's Identification Information (To be completed by the civil surgeon) (continued)

Please complete the following about the applicant:

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

2. Document Identification Number

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

Part 6. 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 8. Civil Surgeon Worksheet**)

   C. ☐ Class A Conditions (See **Item Numbers 1. - 3.** in **Part 8. Civil Surgeon Worksheet**)

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 7. Civil Surgeon's Contact Information, Certification, and Signature

NOTE: Do not sign Form I-693 and do not have the applicant sign in **Part 2.** until all health-related follow-up requirements are met.

Civil Surgeon's Information

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

2. Name of Medical Practice, Facility, or Health Department: Washington Travel Immunizations

Physical Address

3. Street Number and Name: 650 Pennsylvania AV SE | Apt. ☐ Ste. ☒ Flr. ☐ Number: 480

   City or Town: Washington | State: DC | ZIP Code: 20003

Mailing Address

4. Street Number and Name (PO Box): same | Apt. ☐ Ste. ☐ Flr. ☐ Number (if applicable):

   City or Town: | State: | ZIP Code:

Contact Information

5. Daytime Telephone Number: 2022465225

6. Mobile Telephone Number (if any):

7. Email Address (if any): drchevalierscanner@gmail.com

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

Part 7. 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

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 8. 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, 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 will perform further evaluation if needed (chest X-ray).

(1) Interferon Gamma Release Assay (for acceptable IGRAs, consult the *Technical Instructions* and any updates posted on the CDC's website):

☐ 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 (no chest X-ray required)

☐ Positive (chest X-ray required)

☐ Indeterminate (including borderline/equivocal) (no chest X-ray required)

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

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

☐ 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 IGRA exception (Clearly specify the IGRA exception in the Remarks section below.)

(3) Chest X-Ray: Required based on IGRA result, or if specific 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)

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 B2 Pulmonary TB

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

☐ Class B1 Extra Pulmonary TB

☐ Class B, Latent TB Infection

☐ Class B1 Pulmonary TB

☐ Class B0 Pulmonary TB

(4) 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 IGRA, give the reason why an exception applies.)

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

Part 8. Civil Surgeon Worksheet (continued)

B. Syphilis

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

(a) Name of Screening Test

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

(c) ☐ Screening Nonreactive (mm/dd/yyyy)

☐ 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

(b) Date Specimen Reported (mm/dd/yyyy)

(c) ☐ Positive ☐ Negative

(2) Findings:

☐ No Class A or Class B Gonorrhea ☐ Gonorrhea, Class A (untreated)

☐ Gonorrhea, Class B (treated in the last year)

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

Drug: Dosage:

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

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

Part 8. Civil Surgeon Worksheet (continued)

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

(1) Findings:

(a) ☐ No Class A/B Condition

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

☐ Indeterminate, tuberculoid, borderline tuberculoid (paucibacillary)

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

(c) ☐ 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) If you need extra space to complete this section, use the space provided in **Part 11. Additional Information.**

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 that involve any 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). Diagnose mental disorders according to the diagnostic criteria in the most recent edition of the Diagnostic and Statistical Manual (DSM) or another authoritative source, as determined by the director of the CDC. Diagnose physical disorders according to the diagnostic criteria in the most recent edition of the World Health Organization's Manual of the International Classification of Diseases, Injuries, and Causes of Death (ICD) 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 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 extra space to complete this section, use the space provided in **Part 11. Additional Information.**

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

Part 8. Civil Surgeon Worksheet (continued)

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 11. Additional Information.**

4. Other Medical Conditions (List any other Class B conditions, such as hypertension or diabetes, and all required evaluation components as found in HHS's Technical Instructions for Medical Examinations of Aliens in the United States.)

5. Required Referral to Health Department or Other Doctor (To be completed by civil surgeon, if a referral is medically required.)

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

B. Address

Street Number and Name

Apt. Ste. Flr. ☐ ☐ ☐ Number

City or Town

State

ZIP Code

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

Part 8. Civil Surgeon Worksheet (continued)

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

D. Remarks: (Include the name of medical condition and the reasons for referral. **If you need extra space to complete this section, use the space provided in Part 11. Additional Information.**

Part 9. 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 7.** 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. Evaluating Physician or Health Department's Full Name

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

B. Health Department 's Name

2. Address

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

City or Town | State | ZIP Code

3. Signature of Health Department Individual or Other Doctor Performing Referral Evaluation

Signature | Date Signed (mm/dd/yyyy)

4. Name of Medical Practice or Health Department

5. Daytime Telephone Number

NOTE: If you need extra space to complete this section, use the space provided in **Part 11. Additional Information.**

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

Part 10. 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 Part with **Parts 1. - 5.**, and **Part 7.** 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							☐	☐	☐	
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.

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

Part 10. Vaccination Record (continued)

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)

Part 11. 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) | Given Name (First Name) | 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.