Report of Immigration Medical Examination and Vaccination Record

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

USCIS
Form I-693
OMB No. 1615-0033
Expires 03/31/2025

► **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 Legal Name (**Do not** provide a nickname)

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

2. Current Physical Address

In Care Of Name (if any)

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

City or Town | State | ZIP Code

Province | Postal Code | Country

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)
►

4. Immigration Medical Examination Requirement

A. ☐ I am eligible for completion of the vaccination record portion only, because I previously completed an overseas immigration medical examination, signed by a panel physician (refugee or derivative asylee adjustment of status applicants under Immigration and Nationality Act (INA) section 209 and K nonimmigrant visa holders applying for adjustment of status).

NOTE: If you selected this box for Item A. in Item Number 4., you, the applicant, and the civil surgeon are responsible for completing Parts 1. - 5., Part 7., and Part 10.

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

Applicant's Contact Information

Provide your daytime telephone number, mobile telephone number (if any), and email address (if any).

1. Applicant's Daytime Telephone Number

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

3. Applicant's Email Address (if any)

Applicant's Certification and Signature

I certify, under penalty of perjury, that I provided or authorized all of the responses and information contained in and submitted with my application, I read and understand or, if interpreted to me in a language in which I am fluent by the interpreter listed in **Part 3.**, understood, all of the responses and information contained in, and submitted with, my form, and that all of the responses and the information are complete, true, and correct. I understand the purpose of this immigration 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 immigration medical examination, I understand that any immigration benefit I derived from this immigration 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. Furthermore, I authorize the release of any information from any and all of my records that USCIS may need to determine my eligibility for an immigration request and to other entities and persons where necessary for the administration and enforcement of U.S. immigration law.

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

4. Applicant's Signature ➡

Date of Signature (mm/dd/yyyy)

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

Interpreter's Full Name

1. Interpreter's Family Name (Last Name)

Interpreter's Given Name (First Name)

2. Interpreter's Business or Organization Name

Interpreter's Contact Information

3. Interpreter's Daytime Telephone Number

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

5. Interpreter's Email Address (if any)

PATIENT INFORMATION
CLINICAL SERVICES

PATIENT INFORMATION

LAST NAME	FIRST	MIDDLE	
STREET ADDRESS	CITY	STATE	ZIP
			PHONE
SEX	MARITAL STATUS ☐S ☐M ☐W ☐SEP ☐D	DATE OF BIRTH	SS number
EMPLOYER	**(If retired or disabled, what year?)**		OCCUPATION
EMPLOYER ADDRESS	CITY	STATE ZIP	PHONE
RACE	RELIGION REFERENCE		
LEGAL GUARDIAN	**ADDRESS & RELATIONSHIP**		PHONE
EMERGENCY CONTACT	**ADDRESS & RELATIONSHIP**		PHONE

Preferred Language: _____ Do you want interpretation services? ☐ Yes ☐ No

Are you hearing impaired? ☐ Yes ☐ No

Office Staff to Complete:

Refused to provide all individual personal biographical information. ☐

Advanced Health Care Directive Information: ☐ **Offered** ☐ **Accepted** ☐ **Refused**

Date:

AUTHORIZATIONS:

1. Authorization For Treatment: I authorize any medical treatment, anesthetics or surgical procedures as the attending physician deems necessary.
2. Authorization To Release: I hereby authorize the Clinic and its attending physicians to release any information acquired in the course of my examination.
3. Statement of Financial Responsibility: I understand that I am responsible for payment of charges incurred in the course of treatment at the Clinic.
4. I have received Notice of Privacy Practices.

Patient or Authorized Party: _____ **Date:** _____

NOTICE TO APPLICANTS

THE USCIS HAS STRICT REQUIREMENTS REGARDING YOUR PHYSICAL EXAM YOU MUST HAVE ALL THE VACCINES RECOMMENDED FOR YOUR AGE GROUP GIVEN BY THE HEALTH DEPARTMENT AND STAMPED AND INITIALED BY THE PROPER OFFICIALS.

IF THE X-RAYS AND LABORATORY ARE REQUIRED YOU MUST GO TO A USCIS RECOGNIZED INSTITUTION AS DIRECTED.

SHORT CUTS AND ATTEMPTS TO BRING X-RAYS OR STATEMENTS FROM YOUR PHYSICIANS IN YOUR COUNTRY OR ORIGIN OR OTHER UNRECOGNIZED HEALTH CENTERS MAY NOT BE ACCEPTED AND MAY RESULT IN DELAYS OR REFUSAL TO PROCCESS YOUR APPLICATION. THE IMMIGRATION SERVICE WILL ISSUE WAIVERS IF SPECIAL CIRCUMSTANCES EXIST.

NOTICIA PARA LOS APLICANTES

EL SERVICIO DE INMIGRACION USCIS, TIENE REGLAS MUY ESTRICTAS CONCERNIENTES A SU EXAMEN MEDICO, USTED TIENE QUE OBTENER LAS VACUNAS RECOMENDADAS PARA SU EDAD Y CERTIFICADAS POR EL SERVICION DE SALUBRIDAD DE LOS ESTADOS UNIDOS CON INICIALES Y SELLOS DE LAS PERSONAS AUTORIZADAS.

SI SE REQUIERE LABORATORIO Y RAYOS X TIENE QUE IR A DONDE SE LE INDICA.

SI TRAE CERTIFICADOS DE VACUNACION O LABORATORIO DE OTROS PAISES O DE MEDICOS PARTICULARES O INSTITUCIONES NO AUTORIZADAS SU APLICACIÓN PODRA NO SER ACEPTADA RESULTANDO EN RETRAZO O NEGATIVAS PARA PROCESAR SU APLICATION. SOLO EL SERVICIO DE INMIGRACION PUEDE DARLE EXCEPCIONES (WAIVERS)

I UNDERSTAND THIS MESSAGE _____ ENTIENDO ESTE MENSAJE

CONSENT FOR USE AND RELEASE OF PERSONAL HEALTH INFORMATION

I agree to allow Dr. Enrique Zarate and his staff (which may include receptionist, medical assistants, Nurse Practitioner, Physician Assistant, RN, and educators) to use and disclose my health information for the purpose of treatment, payment, or general office operations only.
(this consent is required only once)

Pertinent health information such as lab results or diagnostic reports may be disclosed to a referring specialist or practitioner.

Some personal health information my be necessary to use or disclose in communication with a pharmacist or medical equipment company.

Only with my specific, separate authorization may any information regarding alcohol or substance abuse , mental health information, HIV/ AIDS status be disclosed.

Information regarding sexual abuse, physical abuse, child abuse, elder abuse is mandatory to report WITHOUT client consent. Court orders and law enforcement subpoenas are complied with and DO NOT require client consent. Certain communicable diseases are mandatory to report to local Public Health authorities WITHOUT client consent.

In Emergency situations or if there is a substantial communication problem, health information may be disclosed without formal consent.

I have the right to request an accounting of all disclosures made without my consent.

I understand that Dr. Zarate may choose not to provide medical care for me if I do not agree to this general consent.

Patient signature _____ *Date* _____

Print Patient Name _____

Please circle all that apply to communications between our office and you:

Staff MAY call me at home call me at work leave a voice message mail to my home

Call my cell FAX to me give information only to _____

NEVER give information to _____