Report of Supplemental Medical Screening

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

USCIS
Form I-693A
OMB No. 1615-XXXX
Expires XX/XX/XXXX

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

Part 1. Information About You (To be completed by the applicant.)

1. Full Legal Name (**Do not** provide a nickname)

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

2. Current Physical Address *(USPS ZIP Code Lookup)*

In Care Of Name (if any)

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

City or Town | State | ZIP Code

3. Daytime Telephone Number

4. Mobile Telephone Number (if any)

5. Email Address (if any)

6. Gender
☐ Male ☐ Female ☐ Another Gender Identity

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

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

NOTE: If the applicant has **EVER** used or been assigned other A-Numbers, include the additional A-Numbers in the space provided in **Part 6. Additional Information.**

Part 2. 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)

2. Document Identification Number

Part 3. Civil Surgeon's Contact Information, Certification, and Signature (To be completed by the civil surgeon.)

NOTE: Do not sign Form I-693A 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)

Part 3. Civil Surgeon's Contact Information, Certification, and Signature (To be completed by the civil surgeon.) (continued)

Civil Surgeon Identification Number (CSID) (unless performing the examination under a blanket designation)

2. Name of Medical Practice or Facility

Physical Address

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

City or Town | State | ZIP Code

Mailing Address

4. Street Number and Name (PO Box) | Apt. Ste. Flr. | Number

City or Town | State | ZIP Code

Contact Information

5. Daytime Telephone Number

6. Mobile Telephone Number (if any)

7. Email Address (if any)

Civil Surgeon's Certification

I certify under penalty of perjury under United States law that:

I am a civil surgeon designated by U.S. Citizenship and Immigration Services (USCIS) to examine applicants seeking certain immigration benefits in the United States OR a physician who qualifies under a USCIS 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 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 medical examinations;

I performed a supplemental medical screening for physical, mental, and substance use disorders of the person identified in **Part 1.** of this Form I-693A, 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 supplemental medical screening for physical, mental, and substance use disorders in accordance with the Centers for Disease Control and Prevention's (CDC) *Technical Instructions for Civil Surgeons*, as well as all supplemental information or updates; and

All the information I provided on this Form I-693A is complete, true, and correct, based on the information provided to me by the applicant.

Part 3. Civil Surgeon's Contact Information, Certification, and Signature (To be completed by the civil surgeon.) (continued)

Civil Surgeon's Signature

8. Civil Surgeon's Signature

Date of Signature (mm/dd/yyyy)

(If available, place official stamp or seal of USPHS or military treatment facility here.)

(official stamp or seal here)

Part 4. Supplemental Medical Screening for Physical, Mental, and Substance Use Disorders (To be completed by the civil surgeon.)

1. Date of Screening (mm/dd/yyyy)

2.a. Dates of Follow-up Screenings (if required)

Date of Screening (mm/dd/yyyy)

Date of Screening (mm/dd/yyyy)

Part 4. Supplemental Medical Screening for Physical, Mental, or Substance Use Disorders (To be completed by the civil surgeon.) (continued)

2.b. Findings

- ☐ No Class A or Class B Mental Health Conditions (Physical, Mental, or Substance Use Disorders)
- ☐ Any Physical or Mental Disorder (this excludes addiction or abuse of substances under section 202 of the Controlled Substances Act, but does include other substance-related disorders, such as alcohol abuse)
  - ☐ Class A, with harmful behavior, either current or likely to recur.

    List disorder(s):
  - ☐ Class B, without harmful behavior, or with past harmful behavior that is not likely to recur.

    List disorder(s):
- ☐ Addiction or Abuse of a Specific Substance Under Section 202 of the Controlled Substances Act
  - ☐ Class A

    List substance(s):
  - ☐ Class B, sustained, full remission.

    List substance(s):

2.c. Remarks (Include any therapy given, rehabilitation, counseling, or referrals. If referral made to a mental health specialist or other physician, attach report. If you need extra space to complete this section, use the space provided in **Part 6. Additional Information.**)

Required Referral to Mental Health or Other Physician (To be completed by civil surgeon if a referral is medically required.)

3.a. Type or Print Name of Mental Health Specialist or Other Physician Receiving Required Referral

3.b. Address

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

City or Town | State | ZIP Code

3.c. Date of Referral (mm/dd/yyyy)

Part 4. Supplemental Medical Screening for Physical, Mental, or Substance Use Disorders (To be completed by the civil surgeon.) (continued)

3.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 6. Additional Information**.)

Part 5. Referral Evaluation (To be completed by the mental health specialist or other physician performing the referral evaluation.)

The applicant identified on this Form I-693A was referred to me by the civil surgeon named in **Part 3.** of this Form I-693A. 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.** I have attached any necessary findings/report.

Evaluating Physician or Mental Health Specialist's Full Name

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

1.b. License Number | Issued By (State or U.S. Territory)

Date Issued (mm/dd/yyyy) | Expiration Date (mm/dd/yyyy) | Good Standing? ☐ Yes ☐ No

2. Address

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

City or Town | State | ZIP Code

3. Mental Health Specialist's or Other Physician Performing Referral Evaluation's Signature | Date of Signature (mm/dd/yyyy)

4. Name of Practice | **5.** Daytime Telephone Number

NOTE: If you need extra space to complete this section, use the space provided in **Part 6. Additional Information**. If necessary, attach a separate sheet of paper with any necessary findings/reports.

Part 6. Additional Information

If you need extra space to provide any additional information within this form, 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 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 (if applicable)

2. A-Number (if any) ► **A-**

3. Page Number | Part Number | Item Number

4. Page Number | Part Number | Item Number

5. Page Number | Part Number | Item Number

6. Page Number | Part Number | Item Number