Sample Process Flow and Quality Assurance Checklist for Immigration Physicals

Chart Creation: ***Items to be assembled into the patient's chart prior to consultation with the physician.***

__ **Patient Information Sheet***
__ **Medical Questionnaire***
__ **Immunization Record (Top Section)***
__ **Physical Form (Top Section)***
__ **Photo Identification**
__ **HIV Testing Consent Form****
__ **Pregnancy Form – Females Over Age 15***
__ **Consent for Vaccines***
__ **Copy of Previous Immunization Records**
__ **Copy of Previous Test Results**
__ **Tuberculosis Skin Test (PPD)* or Proof < 90 days Old**
__ **Results of Chest X-Ray if < 6 Months Old**

******Samples of forms are provided.***
**** Each state provides a template for informed consent—download the appropriate form by visiting your State Department of Health website.**

Physician's Examination: ***Items to be completed in the chart after the physician's physical examination.***

__ **Civil Surgeon Copy of I-693 Form**
__ **Copy of Immunization Record**
__ **Copy of Photo Identification**
__ **Copy of Tuberculosis Skin Test (PPD)**
__ **Copy of Chest X-Ray (If Positive PPD)**
__ **Bloodwork Results**

Patient's Packet: ***Items to be returned to the patient upon payment and discharge.***

__ **Provider's Cover Sheet Letter***
__ **Copy of Immunization Record**
__ **Photo Identification**
__ **Copy of Tuberculosis Skin Test (PPD)**
__ **Copy of Chest X-Ray (If Positive PPD)**
__ **Copy of Bloodwork Results**

NOTE: Patient <u>does not</u> receive the I-693 Form. This goes in the INS envelope.

INS Envelope: ***Items to be sealed into the envelope patient returns to Immigration & Naturalization Service.***

__ **3 Remaining I-693 Form Copies**
__ **Original Immunization Record**
__ **Copy of Photo Identification**
__ **Copy of Chest X-Ray (If Positive PPD)**

NOTE: Bloodwork results are <u>not</u> included in the INS envelope.

Sample Form I-693: Report of Medical Examination and Vaccination Record

A writable PDF version is available for download at: U.S. Citizenship and Immigrations Web Site

OMB No. 1615-0033; Expires 10/30/11

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

I-693, Report of Medical Examination and Vaccination Record

START HERE - Type or print in CAPITAL letters: *(Use black ink)*

Part 1. Information About You *(The person requesting a medical examination or vaccinations must complete this part)*

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

Home Address: Street Number and Name | Apt. Number | **Gender:** ☐ Male ☐ Female

City | State | Zip Code | Phone # *(Include Area Code) no dashes or ( )*

Date of Birth *(mm/dd/yyyy)* | Place of Birth *(City/Town/Village)* | Country of Birth | A-Number *(if any)* | U.S. Social Security # *(if any)*

Applicant's Certification
I certify under penalty of perjury under United States law that I am the person who is identified in **Part 1** of this Form I-693, Report of Medical Examination and Vaccination Record, and that the information in **Part 1** of this form is true to the best of my knowledge. I understand the purpose of this medical exam, 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/altered information or documents with regard to my medical exam, I understand that any immigration benefit I derived from this medical exam may be revoked, that I may be removed from the United States, and that I may be subject to civil or criminal penalties.

Signature - Do not sign or date this form until instructed to do so by the civil surgeon | **Date** *(mm/dd/yyyy)*

Part 2. Medical Examination *(The civil surgeon completes this part)*

1. **Examination**

Date of First Examination | **Date(s) of Follow-up Examination(s) if Required:** Date of Exam | Date of Exam | Date of Exam

Summary of Overall Findings:
☐ No Class A or Class B Condition ☐ Class A Conditions (see 2 through 8 below) ☐ Class B Conditions (see 2 through 6 below)

2. **Communicable Diseases 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 *Technical Instructions* at http://cdc.gov/ncidod/dq/civil.htm. The civil surgeon should perform one type of initial screening test only, followed by further evaluation, if needed (chest X-ray).

1. Tuberculin Skin Test (TST):
☐ Not administered (TST exception applies)
Date TST Applied | Date TST Read | Size of Reaction *(mm)*
Result: ☐ Negative (4mm or less of induration) ☐ Positive (≥ 5mm; chest X-ray required)

2. Interferon Gamma Release Assay (IGRA) (for acceptable IGRAs consult the Technical Instructions and any updates posted on CDC's Web site at http://www.cdc.gov/ncidod/dq/civil.htm):
☐ Not administered (IGRA exception applies) | Name of Test | Date Blood Sample Drawn

Form I-693 (Rev. 02/25/10)N

Part 2. Communicable Diseases of Public Health Significance *(Cont'd)*

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

Initial Screening Test Result and Chest X-Ray Determination:
☐ 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 (e.g. HIV)
☐ Chest X-ray required due to TST or IGRA exception (The civil surgeon must clearly specify the TST or IGRA exception in the "Remarks" field 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 (e.g., HIV). Attach a copy of X-ray report.

Date Chest X-Ray Taken | Date Chest X-Ray Read | Results ☐ Normal ☐ Abnormal (Describe results in remarks.)

TB Classification/Findings (check only if chest x-ray was performed):
☐ No Class A or Class B TB ☐ Class B1 Pulmonary TB ☐ Class B2 Pulmonary TB ☐ Class B, Other Chest Condition (non-TB)
☐ Class A Pulmonary TB Disease ☐ Class B1 Extra Pulmonary TB ☐ Class B, Latent TB Infection

Remarks: (Include any signs or symptoms of TB, additional tests, and therapy given, with stop and start dates and any changes.)

Form I-693 (Rev. 02/25/10)N Page 2

Part 2. Medical Examination *(Continued)*

B. **Syphilis**
☐ Serologic Test for Syphilis (Required for applicants 15 years and older)
Date Screening Run | ☐ Screening Nonreactive | ☐ Screening Reactive, Titer 1:
If Reactive, Date Confirmation Run | ☐ Confirmation Nonreactive | ☐ Confirmation Reactive

Findings:
☐ No Class A or Class B Syphilis ☐ Syphilis, Class A (untreated) ☐ Syphilis, Class B (with residual deficit, and treated in the past year)

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

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

Findings:
☐ No Class A/B Condition ☐ Granuloma Inguinale, Class A ☐ Lymphogranuloma Venereum, Class A
☐ Chancroid, Class A ☐ Gonorrhea, Class A ☐ Hansen's Disease (Leprosy, Infectious), Class A
☐ Hansen's Disease (Leprosy, Noninfectious), Class B

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

3. **Physical or Mental Disorders With Associated Harmful Behavior**
☐ No Class A or B Physical or Mental Disorder
☐ Physical/Mental Disorder, With Associated Harmful Behavior, Class A
☐ Physical/Mental Disorder, Without Associated Harmful Behavior, Class B

Remarks: (Include diagnosis, with likelihood of harmful behavior to recur, therapy given, and any counseling, or referrals.)

4. **Drug Abuse/Drug Addiction**
☐ No Class A or B Drug Abuse/Addiction
☐ Substance (Drug) Use, Listed in Section 202 of Controlled Substance Act, Class A
☐ Substance (Drug) Use, Not Listed in Section 202 of Controlled Substance Act, But With Associated Harmful Behavior, Class A
☐ Prior Substance (Drug) Use in Remission, Class B

Remarks: (Include any therapy given, rehabilitation, counseling, or referrals.)

Form I-693 (Rev. 02/25/10)N Page 3

Part 2. Medical Examination *(Continued)*

5. **Vaccinations** (See *Technical Instructions* at http://www.cdc.gov/ncidod/dq/civil.htm for list of required vaccines.)

Vaccine History Transferred From a Written Record				Vaccine Given	Completed Series	Waiver(s) to Be Requested From USCIS			
						Blanket			
						Not Medically Appropriate			
Vaccine	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 completed; write date of lab test if immune or "VR" if varicella history	Not Age Appropriate	Contra-indication	Insufficient Time Interval	Not Flu Season
Specify Vaccine: DT ☐ DTP ☐ DTaP ☐									
Specify Vaccine: Td ☐ Tdap ☐									
Specify Vaccine: OPV ☐ IPV ☐									
MMR (Measles, Mumps-Rubella) or if measles/rubeola or other combination of the vaccines are given, specify vaccine(s):									
Hib									
Hepatitis B									
Varicella									
Pneumococcal									
Influenza									
Rotavirus									
Hepatitis A									
Meningococcal									

Give Copy to Applicant
Results:
☐ Applicant may be eligible for blanket waiver(s) 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.

Name of Applicant
A-Number *(if any)*

Remarks: *(If needed, provide any remarks; e.g., reason for contraindication)*

Form I-693 (Rev. 02/25/10)N Page 4

Part 2. Medical Examination *(Continued)*

6. **List other medical conditions, Class B other** (e.g., hypertension, diabetes)

Part 3. Referral to Health Department Other Doctor/Facility *(To be completed by civil surgeon, if referral was required and made)*

Type or Print Name of Doctor or Health Department Receiving Required Referral | **Date of Referral** *(mm/dd/yyyy)*

Address: (Street Number and Name, City, State, and Zip Code) | **Daytime Phone #** *(Include Area Code) no dashes or ( )*

Remarks: (Include name of medical condition and reasons for referral.)

Part 4. To Be Completed by Physician Or Health Department Performing Referral Evaluation

The applicant identified on this form was referred to me by the civil surgeon named in **Part 5** of this form. I have provided appropriate evaluation/treatment, having made every reasonable effort to verify that the person whom I evaluated/treated is the person identified in **Part 1**.

Type or Print Full Name of Evaluating Physician or Health Department | **Signature**

Address: (Street Number and Name, City, State, and Zip Code) | **Date** *(mm/dd/yyyy)*

Name of Medical Practice or Health Department | **Daytime Phone #** *(Include Area Code) no dashes or ( )*

Remarks: (Attach a separate sheet of paper, if needed.)

Form I-693 (Rev. 02/25/10)N Page 5

Part 5. Civil Surgeon's Certification *(Do not sign form or have the applicant sign in Part 1 until all health follow-up requirements have been met.)*

I certify under penalty of perjury under United States law that: I am a civil surgeon in current status designated to examine applicants seeking certain immigration benefits in the United States; I have a currently valid and unrestricted license to practice medicine in the state where I am performing medical examinations; I performed this examination of the person identified in **Part 1** of this Form I-693, after having made every reasonable effort to verify that person whom I examined is the person identified in **Part 1**; that I performed the examination in accordance with the Centers for Disease Control and Prevention's *Technical Instructions*, and all supplemental information or updates; and that all information provided by me on this form is true and correct to the best of my knowledge, and belief.

Type or Print Full Name *(First, Middle, Last)* | **Signature**

Address (Street Number and Name, City, State, and Zip Code) | **Date** *(mm/dd/yyyy)*

Name of Medical Practice or Health Department

Daytime Phone # *(Include Area Code) no dashes or ( )* | **E-Mail Address**

Part 6. Health Department Identifying Information *(If completed by State or local health department on behalf of a refugee, place a stamp or seal where indicated.)*

Type or Print Name | *(Place State or local health department stamp/seal below.)*

Signature

Date *(mm/dd/yyyy)* | **Daytime Phone #** *(Include Area Code) no dashes or ( )*

Part 7. For USCIS Use Only *(Not to be completed by the civil surgeon)*

☐ 212(g)(2)(B) Blanket Waiver for Vaccination Granted

Remarks: (if needed):

Form I-693 (Rev. 02/25/10)N Page 6

Sample Immigration Physicals: Immunization Record

Supplemental Form toI-693
Adjustment of Status Applicant's Documentation of Immunization
To Be Completed by Civil Surgeon Only

Applicant Identifying Information:

_____ Date of Birth: _____
Last First Middle

___ Male ____ Female Country: _____

Immunization Record:

Vaccine History Transferred from a Written Record				**Date Vaccine Given by Civil Surgeon MM/DD/YY**	**Completed Series or Fully Immune (Check if YES or Date of Lab Test if Immune)**	**Waivers to be Requested from INS:** **__ Blanket or** **__ Not Medically Appropriate**		
Vaccine	**Dates Rec'd MM/DD/YY**					**Not Appropriate Age**	**Contra-Indication**	**Insufficient Time Interval**
DT7DTP								
Td								
Polio (OPV/IPV)								
Measles (or MR or MMR)								
Mumps (or MMR)								
Rubella (or MR or MMR)								
Hib								
Hepatitis B								
Varicella								
Pneumococcal								
Influenza								

Results:

__ Applicant may be eligible for a blanket waiver(s) 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.

Civil Surgeon's Identifying Information:

Civil Surgeon's Name: _____ Date: _____

Civil Surgeon's Signature: _____ Date: _____

Sample Immigration Physicals Forms: Medical Questionnaire

If you answer ***yes*** to any question below, the physician conducting your examination will have further questions for you.

Have you ever had?

YES	NO	
		Heart problems?
		Skin disease or condition?
		Stomach or abdominal conditions?
		Lung problems?
		HIV or AIDS?
		Hypertension (High Blood Pressure)?
		Sexually Transmitted Disease?
		Muscle Conditions?
		Bone Conditions?
		Mental Condition?
		Do you have a criminal record?
		Have you or do you use narcotics or other restricted substances?
		Are you addicted to any drug, prescription or other substance?
		Are you addicted to alcohol?
		Have you been hospitalized for any illness or mental disease?
		Do you have any prior evidence of Tuberculosis?
		Females Only:
		Are you or could you possibly be pregnant?
		Are you trying to become pregnant?
		Date of last menstrual period: _____

_____ _____

Patient Signature **Date**

_____ _____

Physician's Signature **Date**

Sample Immigration Physicals Forms: Pregnancy Questionnaire

	Yes	No
Is there a possibility that you are pregnant?	____	____
Have you been trying to become pregnant?	____	____

Date of Last Menstrual Cycle: _____

Once you have received your immunizations, it is advisable that you do not attempt to become pregnant for three months after immunizations.

By signing, you are indicating that you have read and understand the above statement.

_____ _____

Patient Signature Date

Sample Immigration Physicals Forms: Patient Consent for Admission of Vaccines

I have read the Vaccine Information Statement* provided for:

MMR (Measles, Mumps and Rubella): _____

Varicella (Chickenpox): _____

Tetanus: _____

Tetanus/Diptheria: _____

Hepatitis B: _____

Other: _____ _____

_____ _____

*Note: Vaccination Information Statements may be downloaded from the U.S. Centers for Disease Control and Prevention at www.cdc.gov.

I understand there are benefits and risks from receiving these injections.

I hereby release <Name of Urgent Care Center and/or Provider Administering Vaccinations>, all physicians and medical staff from any and all liability that could result from the above vaccines.

Patient Name: _____

Patient Date of Birth: _____

Signature: _____

__ Patient __ Guardian (if under 18)

Date: _____

Sample Immigration Physicals Forms: Tuberculin Skin Test Certification

This is to certify that a Tuberculin Sensitivity Test was administered to:

_____ on _____ and read on _____.
Patient Name Administration Date Reading Date

_____ _____
Signature Date

Reaction was:

___ Negative ___ Positive at _____ mm

If reaction was positive, what steps have been taken to obtain a negative diagnosis?

I certify that the above-named individual appears to be free from infectious tuberculosis:

_____ _____
Physician Signature (Must be Handwritten) Date

_____
Physician Name (Printed or Typed)

Sample Immigration Physicals Forms: Immigration Physical Form

Patient Name: _____ DOB: _____

Physical Exam:

Normal	Abnormal	
		Head Eye Ear Nose Throat
		Skin
		Abdomen

Normal	Abnormal	
		Heart
		Chest
		Genital

Comments:

Assessment: ___ No Infectious Disease ___ Abnormalities Found

Comments:

Labs/Chest X-Ray/Immunizations:

Type of Lab:

_____ _____

_____ _____

Immunizations:

Type:	Location (Lt/Rt Arm):

_____ Chest X-Ray

_____ PPD (Left Arm)

Return for Results Reading on: _____

Comments:

Statement: I have examined the above-named patient and find the following:

Physician Signature: _____ ***Date:*** _____

Physician Name: _____

Sample Immigration Physicals Forms: Provider's Cover Sheet Letter

<Print on Provider's or Urgent Care Center's Letterhead>

Date: _____

To Whom It May Concern:

This letter is to inform you of the results of your Immigration Physical:

- All results, including laboratory tests and/or x-rays were found to be within normal limits.
- Your immunizations are up-to-date according to USCIS regulations.
- Your I-693 Form, signed by the physician, is sealed in the accompanying envelope and may not be opened by anyone except for immigration officers.

The physician and civil surgeon who performed your physical was Dr. _____.

Please be sure to contact the immigration office regarding your formal interview. If you have any questions or concerns regarding your physical, please contact us at <Phone Number>.

Thank you for your business. It is our hope that we may be of service to you in the future for your urgent health care needs.

Sincerely,

_____

<Provider Signature>